

HOW DO MENTAL HEALTH PRACTITIONERS CONSIDER AND  
UNDERSTAND IDENTITIES, BELIEFS AND PRACTICES THAT ARE  
ASSOCIATED WITH ISLAM WHEN ENCOUNTERED IN CLINICAL PRACTICE

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## **ABSTRACT**

Islam is a growing religion in the UK, however it is also highly politicised and marginalised, as highlighted by the increasing Islamophobia in social and political discourses seen in the West. Discrimination and social inequalities affect Muslim groups in the UK, both of which are shown to have a negative impact on mental health and wellbeing. However, access to inclusive, culturally and religiously sensitive mental health care appears to limit Muslim populations from receiving appropriate mental health support.

Some research has importantly considered Muslim service users' experiences of mental health services and found that mainstream mental health care may not respond appropriately to their religious or cultural needs. Furthermore, experiences of stereotyping and discrimination from professionals were noted. However, ideas about stigma or other 'cultural' barriers to accessing help appear to dominate professional ideas about low access rates.

This research sought to explore the way that mental health professionals construct Islam and whether these go on to impact professionals' judgements and clinical decisions in their contact with Muslim service users.

Semi-structured interviews were conducted with 11 mental health professionals based in the UK. These findings highlighted the way that religious and cultural unfamiliarity with Islam and the prevailing Islamophobic and Orientalist discourses available in the West may affect professionals' perceptions about Muslim service users and lead to decisions about care which exclude or overlook their needs. The implicit prioritisation of Western mental health frameworks was also seen to lead to the discrediting or problematising of different cultural or religious understandings of distress.

However, examples of practice which attempted to reduce this epistemic inequality and adapt interventions to be more in line with Muslim service users' frameworks were highlighted as having fostered improved relationships with Muslim service users, families and communities. The implications of these findings are discussed.

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# 1. INTRODUCTION

## 1.1 Overview

This chapter explores research which may provide insight into how the religion of Islam is constructed by mental health professionals in the UK. The chapter begins by exploring the ways in which religion and spiritual care has been considered in Western mental health frameworks. This is then considered in relation to the epistemological grounding of Western mental health knowledge in positivism and consideration is given to the cultural limitations of this 'Western' approach in an increasingly multicultural and religiously diverse society. A critical analysis in understanding the prioritisation, or dominance, of Western knowledge and experience, as a legacy of colonialism, is then provided. The way that structural inequalities in mental health care are maintained through the marginalisation of experiences, beliefs and practices that deviate from a centralised Western 'absent standard' are discussed.

These ideas are then considered with regards to the way that Islam is constructed within Western society and the way that Muslims, or those racialised to be Muslim<sup>1</sup>, have become increasingly identified as an extremely different, dangerous, despised other; especially so since the so-called 'War on Terror'. Islamophobia and Edward Said's theory of Orientalism are then used to consider the colonial and neo-colonial relationship between the West and 'Islam'. The way that structural inequalities affect the increasing Muslim population in the UK, especially in London, is then considered in relation to mental wellbeing and access to appropriate mental health care. The way that professionals may reflect Western hegemonic constructs in their interaction with Islam, Muslims or racialised Muslims is contemplated, as available literature on how professionals form clinical judgements is summarised.

The chapter concludes with the rationale and research question for the current study.

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<sup>1</sup> Omi & Winant (2014) define 'racialisation' as "the extension of racial meaning to a previously racially unclassified relationship, social practice, or group" (pg. 13). It is argued that this has happened to Islam, with Islam coming to represent 'other' and people being linked to the religion based on racial, ethnic or cultural identifiers that have been associated to Islam, regardless of whether they are Muslim or not.

## 1.2 Religion, Spirituality and Mental Health

### 1.2.1 Religiosity<sup>2</sup> in the UK

Population data from the census in 2011 shows that only 28% of respondents in the UK report having no religion, with only another 7% not stating a response (ONS, 2019). Amongst those identifying as having a religious faith, Christianity is the most common religion (59%), followed by Islam (4.8%). Whilst the census data may be dated, more recent estimates have confirmed that the vast majority of the population may still hold religious or spiritual beliefs (ONS, 2019). Whilst levels of reported Christian faith appear to be decreasing over the past 20 years, there has been an increase in people identifying with minority religions in the UK, especially Islam.

### 1.2.2 Religion and Spirituality

‘Spirituality’ has also gained popularity during this time and is often defined in terms of an individual connection to ideas of transcendence, that are less socially organised and can include, but are not be restricted to, religious contexts (Plante and Thoresen, 2012). Some have described ‘spirituality’ as more varied and ‘inclusive’ than religion (Dein et al., 2010). However, this construction of ‘spirituality’, its growing popularity and relative acceptability when compared with religion, may be associated with what Coyle calls a ‘subjective turn’ in the Western world, whereby the focus on more individualistic and subjectivist reality is sought (2008). Houtman and Aupers (2007) outline how the institutional separation of areas of Western society (e.g. art, science, the state) from religious influence and authority, may have led to a value pluralism; which in turn eroded the unquestioned legitimacy of the ‘traditional’, moral values associated with the Christian tradition, resulting in “detraditionalisation” (pg. 308).

Indeed, Coyle and Lochner (2011, pg. 1) write that “within Western liberal social discourse, religion has often been associated with negative qualities such as conflict, control, judgmentalism and anti-intellectualism”. Coyle (2008) contextualises the rise in popularity of spirituality to the ‘cultural fear and panic’ in the West towards organised religions, especially Islam.

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<sup>2</sup> The term “religiosity” means reflecting religious phenomenon; in English it is more often used to refer to levels of religious practice (Angel et al., 2006). In this study ‘religiosity’ refers to the level of religious identification or practice one communicates; as is commonly used in psychology literature.

### 1.2.3 Religiosity in Mental Health Service Users

Research has shown that the religiosity of mental health service user is in line with religiosity in the population (Kroll & Sheehan, 1981; Neeleman & Lewis, 1994). In the UK it has been found that 50% of mental health service users report religious or spiritual beliefs that they believe are important to their recovery, however, they feel this is not sufficiently considered in their mental health care (Faulkner, 1997). Whilst these findings are dated, Koenig's recent reviews into the use of religious coping shows a persistence in the prevalence of religiosity, in those who access mental health services, over time (Koenig 2009; 2012; 2015).

### 1.2.4 Religious coping<sup>3</sup> and evidence-based practice

The study of religiosity and wellbeing has seen an "explosion" since the mid 1990's. Koenig conducted a systematic review of this literature, looking predominantly at the link between religious coping and mental wellbeing (2012). A positive relationship was found between holding religious or spiritual beliefs and coping with adversity and illness. Furthermore, improved mental health outcomes were noted in experiences of depression, suicidality, substance misuse and anxiety. Koenig notes that these findings challenge the often-conflated idea that religion exacerbates mental health problems due to stigma, shame or guilt. Whilst some research did note such effects, the majority found religiosity to be supportive of mental wellbeing. Moreira-Almeida and colleagues suggest that when evaluating this area of research "preconceived opinion" must be acknowledged to address the "radical scepticism that rejects even good scientific evidence" (2006, pg. 243).

### 1.2.5 Religion and Mental Health

Historically, the care of people with mental health needs in the UK was undertaken by religious institutions (Koenig, 2009). The separation between religion and mental health emerged in more recent times, heavily influenced by influential post-enlightenment intellectuals, scientists and psychiatric professionals, such as Freud, Ellis and Skinner, who all held secular beliefs and pathologised religion (Freud, 1927; Ellis, 1980; Skinner, 1971).

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<sup>3</sup> Religious coping refers to ways in which an individual's global religiousness may translate into specific religious beliefs and practices that are, in turn, directly related to health and well-being (Pargament, 1997).

Mental health provision is in the present time continues to be dominated by biological or bio-psycho-social approaches, which are heavily influenced by positivism and science-based models of understanding mental health. Healthcare workers have been shown to hold views of religion as “irrational, outdated and dependency-forming” (Dein, 2004, pg. 287) and there continues to be a ‘religiosity gap’ between mental health care providers and clinical or non-clinical populations.

### 1.2.6 The Religiosity Gap

#### *1.2.6.1 Clinical Psychology:*

Research has shown psychologists to be significantly less religious than the service users they work with. Of trainees accepted onto training, only 26% declared holding a religion, with 5% preferring not to say. The vast majority of those who did identify as religious held Christian faith (20%). This pattern appears consistent since the reporting of data began in 2010 (Leeds Clearing House, 2018) and other research with qualified Psychologists (Smiley, 2001).

Whilst some psychologists tend to view religion as helpful to a person’s mental health (Delaney, Miller & Bosono, 2007), obstacles in raising issues of spirituality in clinical work include; unease at having discussions about religion, the lack of relevance of religion to psychologist’s own life, psychologists’ own perspectives of religion as controversial or problematic, and a lack of language in which to converse about religion, due to training limitations (Crossley & Salter, 2005).

Psychological professions have been shown to be high in politically ‘liberal’ identifying individuals, who have a preference for humanistic approaches to mental health (Bilgrave & Deluty, 2002; Norton & Tan, 2019). Humanistic approaches focus on individualistic pursuits, free will, self-efficacy and self-actualization in recovery and have historically devalued organised religion or the centring of experience around God or a collective (Maslow, 1970).

#### *1.2.6.2 Psychiatrists and Mental Health Nurses:*

Studies surveying religiosity of the profession of Psychiatry also show less religiosity in psychiatrists, compared with clinical and non-clinical populations (Baetz et al, 2004). Neeleman and King (1993) studied 231 consultant and trainee psychiatrists in London and found that 27% reported a religious affiliation and 23% reported a belief in God. Psychiatrists also showed lower religiosity when compared with other medical specialities and mental

health professions (Curlin et al., 2007; Bergin & Jensen 1990). Importantly these studies reported that psychiatrists feel religion to be important to mental health, however religious inquiry was not incorporated into clinical practice. Debates about the appropriateness and professionalism of integrating religiosity with psychiatric practice continues to this day (Poole, Cook & Higgo, 2019).

Research has found that nurses have higher rates of religiosity than other helping professions (Oxhandler et al., 2017; Taylor et al., 2017). McSherry and Jamieson surveyed 4054 registered nurses in the UK and found that almost 75% of respondents identified holding religious beliefs; predominantly Christian, and many of whom identified as practicing their religion (2013). These nurses reported a lack of confidence in providing spiritual care, due to a lack of professional guidance and training, as well as a ‘preoccupation with political correctness’; with some noting a ‘growing intolerance’ towards religiosity in their professional spaces, which generated fear and anxiety amongst nurses who have religious belief.

#### 1.2.7 Recognition of Faith Needs in Mental Health Policy

The Department of Health have highlighted the need for healthcare professionals to have more awareness of spiritual understandings of mental health, that differ from the biopsychosocial explanations prevalent in professions (Department of Health, 2009). Furthermore, the recent government strategy, *No Health without Mental Health*, highlighted how “different conceptualisations...between an individual and services will affect engagement and success of treatment and care” (Department of Health, 2011). Indeed, many professional bodies, including the Royal College of Psychiatrists (RCP), Royal College of Nursing (RCN) and the British Psychological Society (BPS) have policies within their own professional guidelines highlighting that professionals’ own beliefs should not inhibit them from engaging with the religious beliefs of service users and that religion should be incorporated into mental health interventions (RCP, 2013; RCN, 2012; BPS, 2017).

Despite this, research suggests that religious service users hesitate to access secular NHS services due to fears of not being able to discuss spiritual concepts or that their religious beliefs will be minimised, neglected, pathologised or contested by non-religious professionals (Mayers et al., 2007). Therefore, people with religious beliefs may seek

alternative forms of support from faith leader or faith-based organisations (McCabe & Priebe, 2004; Chadda et al., 2001).

#### 1.2.8 Religion and Ethnicity

The 2011 census data showed that up to a 28% of people with White British ethnicity report ‘no religion’, compared with 19% in White-other and less than 10% of people from Black and Asian backgrounds. Indeed, in the recent *No Health Without Mental Health* strategy, the Department of Health highlighted that more people from Black and Minority Ethnic (BME) backgrounds identified themselves as religious, meaning that “by failing to address religion, services disproportionately affect people from BME backgrounds” (2011).

Research has shown that people from Black, Asian and Mixed heritage (BAMh) backgrounds may conceptualise distress using spiritual frameworks and social causes more than their white counterparts (McCabe & Priebe, 2004). Therefore, the intersection of religion and ethnicity is important to note given the racial disparities already faced by BAMh people in access to appropriate mental health care (Alston, 2019).

The increase in multiculturalism and the diversification of religious beliefs in the UK population makes it important for healthcare providers to evaluate the current standards of mental health care provision and consider whether it is adequately responding to cultural and spiritual needs.

### **1.3 The “Absent Standard”**

Western mental health care is underpinned by constructs about what causes ‘mental illness’. This section will explore how these constructs may be based on an unquestioned secular, White, Western standard, which undermines and marginalises cultural or religious diversity in the UK population.

#### 1.3.1 Prioritising Western Scientific Disciplines in Healthcare

Mental health care in the UK is premised on providing holistic bio-psycho-social models of intervention. However, some authors have argued that the psychosocial aspects of mental health difficulties are often overlooked in this approach, with a disproportionately high focus on biological aetiology, medical research and interventions (Read, 2005).

#### *1.3.1.1 Differing Epistemologies and Colonialism*

In broad terms, Western paradigms of mental health and the mind/body dualism, often differ from eastern, more holistic, models of mind-body continuation (Fernando, 2004). Fernando writes about these differences, however, not in absolute terms; with an understanding that there is overlap and exchanges between Eastern and Western practices throughout history. He argues that whilst Western approaches may value control and understanding of symptoms, in often individualised terms; Eastern approaches are more focussed on acceptance, contemplation and connectedness amongst people and amongst the parts of the self and the spiritual (mind-body-spirit). Fernando highlights the role of European colonialism in the denigration and appropriation of Eastern values, knowledge and traditions; including in how we might come to understand distress.

#### *1.3.1.2 European Enlightenment*

The denigration of religion more broadly in Europe emerged following the Enlightenment, where scientific and humanistic thinking began to dominate in the ‘intellectual’ sphere and religion came to be pathologized, declining in institutional and ideological power (Moreira-Almeida, Neto & Koenig, 2006; Houtman & Aupers, 2007). This led to a rise in secularity in Europe, including in mental health care.

### 1.3.2 Creating an “Absent Standard”<sup>4</sup>

Mental health approaches used in the UK are strongly rooted in Western secular and scientific frameworks and are therefore only “culturally normal” to the context from which they are derived (Fernando, 2005). However, criticisms have been made of Western psychiatry and psychology for applying their knowledge as culturally universal.

In so doing an ‘absent standard’ has been created whereby the values and experiences of predominantly White, Western people are used as a basis for ‘knowledge’ in mental health

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<sup>4</sup> Sampson (1993) introduced the term “absent standard” to describe the way that ideas about a culture (X) can be formed by implicit comparisons being made against an ‘absent’ other culture (Y). However, this absence is not neutral, and is instead reflective of historical relations of power between different groups. Dominating groups are granted privilege through the implicit (absent) standard that they come to represent as they become a hidden evaluative frame from which other groups are compared with. This process reinforced their power and domination, as the their culture becomes a prioritised, unexamined norm, which escapes scrutiny, yet scrutinises and defines ‘other’ cultures and their acceptability.



frameworks (Gaines, 1995). Consistent with Sampson's definition, this absent standard has led to a process whereby 'culture' has become something that refers to what only non-white, non-western people are seen as having in mental health care (Harper, 2011).

This leads to what Kleinman has termed 'category fallacy'; the imposition of a dominant culture's diagnostic categories on to people belonging to another culture, where they lack coherence and established validity (1988). In so doing, behaviours, beliefs and actions that do not align with those deemed as 'standard' can become either ignored or pathologised.

### 1.3.3 The Absent Standard in Research & Care Provision

Arnett (2008) found that 96% of participants used in psychology research came from industrialised, western countries, despite the fact that this group only represent 12% of the global population. People from BAMh backgrounds are underrepresented in clinical trials and research (von Wagner et al., 2011) and the dangers this poses in reproducing and exacerbating health inequalities, especially in mental health, by providing ineffective treatment to minority groups in society has been highlighted (Rugkåsa & Krysia, 2011).

#### *1.3.3.1 Race and Mental Health Care:*

Public Health England has highlighted the impact of health inequality affecting people in minority ethnic groups in the UK (2018). A recent report from the Race Equalities Foundation found that people from BME backgrounds were at higher risk of mental health difficulties and were disproportionately impacted by the social detriments associated with poor mental health (e.g. low SES, housing difficulties) (Bignall et al., 2019).

However, these groups are less likely to have their mental health problems identified or treated by their GPs (Maginn et al, 2004); be referred to specialist mental health services (Memon et al., 2016); or access psychological therapies (Department of Health, 2005); and are subject to misdiagnosis (Burr, 2002), possibly due to discriminatory assumptions made by professionals (Bhugra, Desai & Baldwin, 1999). BME people also report harsher experiences of services, poorer outcomes and fears of experiencing discrimination (Arday, 2018; Baker,

2020, Halvorsrud et al., 2018), leading to ‘circles of fear’<sup>5</sup> (Sainsbury Centre for Mental Health, 2002).

#### 1.3.4 The Absent Standard in Professionals

Fernando and Keating (2008) suggest that the lack of diversity in mental health professions plays a part in maintaining the ‘circles of fear’, a sentiment echoed in service user research (Arday, 2018). This may be indicative of a real problem of diversity within mental health professions; however, it may also indicate the embodiment of a western ‘absent standard’ by mental health professionals through their professional identities.

##### *1.3.4.1 Workforce Diversity:*

The NHS workforce is reported to be as ethnically diverse as the population, with 13% of its staff belonging to BAME backgrounds (NHS Digital, 2019; ONS, 2019). However, research describes the ‘snowy white peaks’ of the NHS (Kline, 2014), whereby there is disproportionately high representation of people from White ethnic groups in senior management or leadership positions and on Trust boards; often unrepresentative of the local populations.

This is repeated in mental health professions. Whilst diversity data from the profession of Nursing has shown an overrepresentation of people from BAMh backgrounds in the profession (20.5%) compared with population figures, the number of BAMh nurses in senior positions remain disproportionately lower than White nurses (NHS Digital, 2019).

Similarly, despite the diversity of medical professions, racial disparities appear in senior Psychiatry positions; with an overrepresentation of White doctors, who trained abroad, and an underrepresentation of UK trained BAMh doctors attaining Consultant Psychiatrist positions (Goldacre et al., 2004).

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<sup>5</sup>. ‘Circles of Fear’ is the fear and avoidance of mainstream mental health services from BAMh populations due experiences of institutional racism and inappropriate or discriminatory care, re-enacted by mental health providers, as a reflection of wider societal inequalities and prejudice. It also encompasses the discomfort or avoidance from mental health practitioner in engaging with BAMh populations due to negative stereotypes held in social discourses about them and a ‘professional paralysis’ when engaging in discussions about discrimination.

Clinical Psychology equally struggles with diversity in its profession, with BAMh candidates being disadvantaged when attempting to entering the profession (Scior et al., 2007), despite high levels of BAMh applicants. The discrimination that BAMh people experience on their journey to becoming clinical psychologists, before, during and post qualification, are well documented (Adetimole, Afuape & Vara, 2005; Ragaven, 2018).

#### *1.3.4.2 Cultural Competence:*

Definitions of cultural competence often incorporate the need for developing awareness of one's own culture, pre-conceptions, assumptions and biases (Vieten et al., 2013). However, cultural competence training has been criticised for focussing too narrowly on building knowledge of the beliefs held by specific groups, rather than more broadly on how to ensure beliefs and practices are linked to provide acceptable care (Bhui et al., 2006). Truong, Paradies and Priest (2014) found that dialogues about structural inequalities and the importance of self-reflexivity of one's own personal or professional culture were rarely mentioned in cultural competence training.

#### 1.3.5 Whiteness, the Absent Standard and Decolonising Mental Health

Taken together it is possible to consider how mental health professionals may be both a product of and a contributor to the maintenance of a White, Western 'absent standard' in mental health care.

Wood and Patel (2017) use the term 'Whiteness' to describe the invisible power and privilege experienced by groups, based on the hierarchisation of cultural and ideological practices, which result in the racialised and intersectional oppression of difference. In this sense it is similar to the understanding of an 'absent standard' in mental health care. They suggest that simply increasing the 'representation' of minoritised groups (e.g. BAMh, Religious, low SES) in professions is insufficient to tackle the problem, as it does not eradicate the deleterious effect that ideological power structures have on the different understandings, needs and experiences of people from minoritised backgrounds. Yan similarly writes of the suppression, as opposed to the utilisation, of the cultures of social workers, especially those from minority backgrounds, in professional training; identifying that, to be seen as competent is to take on a 'white identity' (2005, pg. 18-19). Indeed, this may explain some of the barriers and conflicts noted by professionals on how to integrate cultural or religious

differences into their clinical practice or professional identities (McSherry and Jamieson, 2013; Ragaven, 2018)

Sakamota (2007) reflects on the colonial roots in social work, shared by psychiatry and psychology, as continuing through the failure to challenge Eurocentricity in our models and approaches and the continued conceptualising of ‘culture’ as something only non-western ‘others’ have; which is exacerbated by ‘diversity’ and ‘cultural competence’ agendas. Sakamota and other practitioners and academics highlight the need for an explicit decolonising approach to reviewing mental health approaches and practice in the UK. At this present time in history it may be important to apply such consideration to a highly politicised, othered and discriminated faith, Islam, which is affected by both religious and racialised prejudice and whose prejudice has deep roots in colonial history.

## **1.4 Islam**

### 1.4.1 Islam in the UK

Islam is the second largest religion in the world, with up to 1.8 billion followers (Muslims); making up 24.1% of the global population (Lipka & Hackett, 2017). In the UK, the most recent census in 2011 reported that Muslims made up 4.4% of the population in the UK with 2,516,000 people identifying Islam as their religion, however more recent data suggests that this figure has grown to over 5% (ONS, 2019). London has the highest percentages of Muslims in the UK, with 12.4% of residents identifying as Muslim; with some boroughs reporting up to 30%, including Newham and Tower Hamlets.

Muslim migrants represented a range of different nationalities and ethnic groups, often holding integrated religio-national identities influenced by both their homeland cultures and their related interpretation and practice of Islam (Modood, 1994; Parekh, 2008).

### 1.4.2 Islamophobia

Muslim activists and academics began to note the unique way that racism was being expressed towards Islam from the 1980’s (Allen, 2010: pg.10-13), however, the idea of Islamophobia only become popularised following its use by the Runnymede Trust in their report ‘*Islamophobia: A challenge for us all*’ (Conway, 1997).

This report defined Islamophobia as an ‘unfounded hostility towards Islam’ and the consequential discrimination this hostility causes to individuals and communities that are associated with Islam (Conway, 1997). Whilst acknowledging that this phenomenon has been around for many centuries, this report was commissioned in response to a noted increase in anti-Muslim sentiment both in Britain and wider global contexts over the preceding 20 years.

The report suggested that closed views of Islam as an ‘extremely different’, ‘rigid’, ‘aggressive’ and ‘regressive’, religion both inferiorised Muslims and depicted Islam as incompatible with Western values. These narratives, prominent in social and political discourse, normalised and legitimised anti-Muslim sentiment and naturalised the rejection of the values and viewpoints of Muslims in the West.

One example may include the outlawing of women’s Islamic dress including the *niqab* (face covering) or *hijab* (headscarf) in public spaces or in work or educational institutions across many countries of the West. Reasons often cited for this outlawing include; its conflation with terrorism and security threats; perceived incompatibility with social integration; and a perceived incompatibility with European values of gender equality and so-called women’s liberation; despite expressions from European Muslim women that the ban itself was oppressive (Zempi, 2019).

Some authors have contextualised such laws and social and political narratives as symptoms of the colonial history between the West and the Islamic world (Al-Saji, 2010). Indeed, whilst Islamophobia may be something that has only been discussed in more recent history, it holds close ties to the earlier concept of Orientalism.

#### 1.4.3 Orientalism

Historically, the term Orientalism was used to describe the acquired knowledge or study of customs, cultures, languages or peoples of the ‘Orient’, referring to Asia or the ‘East’. Within this there is a centralising of a Western viewpoint (‘East’ of where?), when considering the ‘East’. However, this positioning and the narratives created from it were not considered critically in popular discourse until the 1960’s. Scholars including Abdel-Malek, A.L Tibawi and Edward Said began to publish work questioning the narratives that had been embedded into so-called ‘knowledge’ of the ‘Orient’, identifying essentialised and inferiorising depictions of ‘Muslims’ or ‘Arabs’ and the Islamic empires in Western literary, artistic and

scholarly documentation. Edward Said used the eponymous term ‘Orientalism’ to capture this phenomenon (Said, 1978). These authors considered the connection between this production of mythical and stereotypical ‘knowledge’ about ‘Muslims’ and ‘Arabs’ to the geopolitical ideologies relating to Western colonialism and imperialism.

#### *1.4.3.1 Orientalism and Western Colonialism*

It has been argued that Orientalism may have its roots in Western colonialism, starting with the ‘militaristic pilgrimage’ from Christian Europe in the early 12<sup>th</sup> and 13<sup>th</sup> centuries.

Christian criticism of Islam at the time depicted the religion as fraudulent and depicted Muslims in a fantastical way, as exoticised, immoral, ungodly, barbaric peoples who forced the spread of the religion through violent means. These mythologies were used to justify the colonial crusades into the Middle East, to reassert European Christian identity and power, against the perceived threat of a growing Islam (Allen, 2010, pg. 26-27).

After the European age of enlightenment, the Western world became more occupied with secularity, scientism and liberalism. Modern orientalism involved the ideological capture of the ‘Orient’, formed on the study and intellectual conquest of the ‘Orient’ and Islam, by Western scholars. The ‘scientific’ knowledge of the West assumed a status of dominance and truth (Burr, 2002). Therefore, the study of the Orient, through the gaze of Western thought and judgement, was underpinned by unquestioned depictions of underdeveloped people of the Orient, who existed in direct contrast to the liberal, progressive, rationalism of Western society. Such narratives were echoed in the post-World War I colonisation of the Middle East by British and French governments, as ‘Arabs’ and Muslims’ were considered underdeveloped, barbaric and “unamenable to civilization” (Comaratta, 2015, pg. 108).

It is suggested that the elements of Orientalism which work to ‘other’ Islam remain in a reserve of reference in the West, available to be emphasised or engaged with in a variable way depending on the changing contexts, time and place (Allen, 2010, pg. 35-40). Allen argues that present day Islamophobia is indicative of the socio-political context since the late 20<sup>th</sup> century, positioning Islam in politicised and militarised frames to serve Western neo-colonialism.

Continuation in inferiorising discourses about ‘Muslims’ and ‘Arabs’ have led to ongoing undermining of the nationalist, self-governing aspirations in the countries of the Middle East,

by Western powers. The decontextualisation of political struggles and the emergence of extremism in Muslim regions has been noted throughout history in Western scholarly writing (Cherkaoui, 2010), especially the omission of the contribution Western foreign policy has had in maintaining destabilisation in these regions (Fritsch-El Alaoui, 2005).

Focus has instead maintained on essentialists depicts of Islam or Muslims as violent and uncivil, justifying the 'war on terror'. Indeed, the September 11<sup>th</sup> attacks (9/11) on the World Trade Centres in 2001 were framed as an act of war by 'Islamists', motivated by a hatred of the West for its 'freedoms and progressive way of life' (McChesney, 2003).

Further violent attacks in the UK, including the London 7/7 bombings and, more recently, the Manchester Arena bombing in 2017, have led to a continued sense of threat in the West and Britain of so called 'Islamic terrorism'.

#### 1.4.4 The Role of Discourse and Hegemony

Said used Foucault's concept of '*power-knowledge*' to analyse how the creation and ownership of knowledge about the 'Orient', by Western scholars, reflects an exertion of Western dominance over the discourses available about the Islamic world. This formed what Foucault calls a 'regime of truth'; whereby Western superiority over the 'Orient' became reproduced and consolidated through the control of 'knowledge' production (Foucault, 1980, pg. 131).

Said also used Gramsci's concept of 'hegemony', to understand the way that ideological control is maintained through consent (rather than coercion), through the repetition and reiteration of ideas which represent the values and institutions of power, in different areas of a culture (e.g. science, art, literature); leading to a naturalisation or 'common sense' acceptance of those ideas in society (Gramsci, 1971). Said believed that the embedding of Orientalism into Western knowledge and culture imprinted Orientalist depiction of 'Muslims' and 'Arabs' (exotic, irrational, despotic, barbaric) in the Western frame of mind. Said suggests that this depiction was not accidental or consequential, but indeed indicative of the political, and specifically imperialistic, endeavours of the West towards the East over history (Cherkaoui, 2010).

### 1.4.5 Depictions of Muslims and Islam in the UK Today

#### *1.4.5.1 Conflation of Islam with terrorism:*

The controversial uses of the terms ‘Islamic terrorism’ and ‘Islamic extremism’ have been criticised for their unjust pairing of the religion of Islam, and its 2 billion followers around the world, to the individuals and groups committing acts of violence and terror (Jackson, 2007). This view holds that a divisive discourse is created associating Islam with terrorism; the ‘bad’ ‘other’ whose identities pose a threat to Western values (Kundnani, 2014; Noor, 2010). D’Amato (2019) writes about how post-9/11 ideas of terrorism have been increasingly understood and discussed as a threat to national values, rather than to the physical safety of western populations. This threat is associated with Islam more broadly, in what D’Amato calls the “Islamization of criminal behaviour” (pg. 342), leading to a “representation of terrorism as an extreme form of religious criminality that might nonetheless reinforce discrimination and securitising religious and social practices more than violent behaviour (Ragazzi, 2016a, 2016b)” (pg.343).

This may be seen as evidenced by the PREVENT policy, which is a counter-radicalisation policy that makes it a statutory duty for staff working in public services, e.g. education or healthcare, to identify and report individuals they suspect may be vulnerable to radicalisation. However, in practice referrals to PREVENT are heavily influenced by racialised framings about Muslims, which makes them more likely to be referred (CAGE, 2018; Younis & Jadhav, 2019a).

#### *1.4.5.2 Islam as a threat to the ‘western way of life’:*

Ahmed and Matthes (2017) conducted a meta-analysis of published studies which looked into the media’s role in construction of a Muslim and Islamic identity, including in the UK. They noted an increase in negative portrayals of Islam and Muslims after 9/11, framing the religion mostly along the lines of religious extremism or culturally incompatible with the West.

Such narratives have contributed to the evaluating of Muslims in terms of (dis) loyalty, (non) integration (un)assimilability in social debates around the ‘appropriate’ role of Islam in the West (Nagel & Staeheli, 2009, pg. 98-99).

This conflation has served to narrow the understanding of Islam and Islamic societies away from their rich cultures and diverse populations, practices and histories; into colonial,



essentialised, Islamophobic depictions of a dangerous and incompatible and inferior ‘other’, in need of civilising.

## **1.5 Islam and Mental Health**

### 1.5.1 Muslim Experiences in the UK, Discrimination and Wellbeing

Sheridan (2006) explored experiences of Islamophobia in British Muslims, before and after 9/11. Their findings showed that Anti-Muslim sentiment was high before 9/11, with the highest levels of hate crimes and discriminatory treatment reported as occurring in the domains of education, employment, housing and law, when compared with other religious groups. However, there was a substantial increase in experiences of both direct and indirect forms of discrimination following 9/11.

It has been shown that Muslims in the UK face social adversity, in addition to and perhaps in connection with their experiences of Islamophobia. Muslims in the UK have the highest levels of unemployment compared with any religious group in Britain. They are underrepresented in 'higher managerial, administrative and professional occupations' and have slightly lower levels of education attainment in reaching degree level qualifications or above. Furthermore, 46% of the Muslim population live in the most deprived areas of the UK (Social Mobility Commission, 2017). These authors outline the implications of these conditions on mental wellbeing, access to social resources such as healthcare and education, as well as opportunities for social mobility.

In their systematic literature review, Samari, Alcalá and Sharif (2018) found Islamophobic discrimination experiences to be related to poorer mental and physical health, with fear of further discrimination acting as a barrier to healthcare access. Being a ‘highly visible’ Muslim was also associated with increased levels of depression. Samari and colleagues included research with both Muslim and those who are perceived to be Muslim, due to the racialisation of the religion.

### 1.5.2 The Racialisation of Islam

Frantz Fanon describes the process of racialisation as being linked to dominating groups (European colonisers) justifying dominance and oppression through the process of essentialising, inferiorising, othering and ultimately dehumanising, those who were colonised

(non-white groups) (Isin, 2012). Isin points out the parallels between this and Said's critique of Orientalism and the West's construction of 'Muslims'. Therefore, racialisation can be understood as the homogenising of diverse groups, based on specific characteristics, to form a racial entity, in order to maintain a focus on limited, fixed narratives about that population.

It is argued that the racialisation of religion has occurred with Islam, whereby Muslims are constructed as an unwanted 'other', whose values pose a threat to Western society (Islam, 2017).

Islamophobia affects not only those who identify as Muslim, but also anyone who is linked to Islam through a racial, ethnic or cultural identity that has been ascribed as a potential signifier of Islam. Typically, this includes those of Middle Eastern, North African or South Asian descent who are homogenously thought of as synonymous with 'Muslims'. Other racialised factors include certain phenotypical features (e.g. 'brown skin', 'round eyes') or cultural practices (e.g. traditional or religious clothing, like the wearing of a Turban) (Joshi, 2006), despite the vast range of cultures, ethnicities and religions which are associated with these characteristics. Indeed, Allen and Nielsen summarised findings of anti-Islamic reactions across the 15 EU member states, following the events of 9/11, and found that visual identifiers such as wearing the hijab, looking 'Muslim' or 'Arab', and even Sikh men wearing turbans, led to increased targeting and discrimination (2002).

### 1.5.3 Muslim Experiences of Mental Health Services

Mental health literature has been inconsistent in reporting religious identity and there has been sparse investigation into the experiences of different religious groups. Research that has been conducted about Muslim mental health has often been inferred from researching very specific ethnic groups, such as Pakistani or Bangladeshi populations, as these ethnicities comprise a large percentage of Muslims in Britain (Hussain, 2009). Hussain warns against this conflation and supports a need to look at social, cultural and religious contexts and identities in a nuanced way; a sentiment echoed by other researchers working with these minority populations. (Tarabi, Loulopoulou & Henton, 2020).

However, despite the limitations highlighted, some important work with service users identifying as Muslim or from majority Muslim ethnic groups will now be outlined to highlight common experiences of mental health services.

#### *1.5.3.1 Stigma:*

Stigma within Muslim families, communities and society about having a mental health difficulty or seeking support for this from services have been commonly cited as reasons for not accessing mental health services (Chew-Graham et al., 2002; Youssef & Deane, 2006; Rethink, 2007; Ahmed 2019). This has included fears around social opportunities such as acceptance in the community.

However, some authors conclude that such stigma towards mental health is universal and merely assumed to be greater in the Asian population, providing an easy explanation for the under-utilisation of psychiatric services by these groups (Hussain & Cochrane, 2004).

#### *1.5.3.2 Misunderstanding, Fear and Mistrust:*

Further research has also suggested a lack of desire in Muslim patients in accessing mental health services, due to concerns about the sensitivity mainstream services would have to their cultural or religious identities, beliefs or experiences (Rethink, 2007; Chew-Graham et al., 2002; Weatherhead & Daiches, 2010).

Other research has also highlighted stereotyping or fear of stereotyping experienced by South Asian, Arab and Muslim patients, which have affected healthcare professionals' judgements on what treatments they have offered to the patient (Mir & Sheikh, 2010; Weatherhead & Daiches, 2010; Youssef & Deane, 2006).

Furthermore, some service users have voiced concerns about the pathologising of their experiences, due to the lack of consideration given to their positions in society as Muslim and the socio-political context in which they live. Examples include the idea of 'paranoia' being associated by professionals to very real Muslim experiences of being censored, securitised and surveyed in a post-9/11 world (Byrne, Mustafa, & Miah, 2017).

Furthermore, the way that the media and wider society have responded to Islam has left Muslim populations feeling cautious about what they can say to mental health services and how it will be received and managed (Muir, 2016).

#### 1.5.4 Creating a New ‘Circles of Fear’

. Research has highlighted the role that the ‘psychological vulnerability’ to ‘radicalisation’ discourse has in legitimising a pre-emptive, interventionist and securitising approach in education and healthcare towards British Muslims (Coppock & McGovern, 2014). Research has shown that the PREVENT agenda has acted as a barrier to Muslim communities accessing mental health support (Byrne, Mustafa, & Miah, 2017) and contributed to the erosion of trust between Muslim communities and statutory services, due to the infringement that the securitisation of Islam has caused on the right of these communities to expression of thought, religion, privacy and to be protected from discrimination (Open Society Foundations, 2016).

Byrne and colleagues discuss the way that wider social narratives about Islam, which are othering and loaded with negative stereotyping and suspicion, may be imprinted into mainstream mental health services, especially through policies such as PREVENT. They outline how this creates new ‘circles of fear’ with Muslim communities.

#### 1.5.5 Differing Conceptualisations?

As noted, the compatibility of Western models of mental health with Islamic or non-western spiritual or cultural models is often questioned, with regards to accessing mental health care.

##### *1.5.5.1 Islam, Culture and Understanding ‘Mental Health’:*

Many conceptualisations of ‘Mental Health’ exist within the diverse Muslim populations around the world. The idea of ‘mental health’ itself is a Western construct and Islamic or local cultural beliefs have equally informed constructs of distress for Muslims.

Some commonly referenced constructs for understanding distress in Islam include belief in; *Black Magic*, the curse of *Evil Eye* and *Jinn* influence or possession (Manawar, 2017). Furthermore, ideas around mental illness as being indicative of not being close to *Allah* or the will of *Allah*, as a test of faith or punishment, are also cited (Rethink, 2010; Ahmed, 2019). These constructions are not fixed however and are commonly being debated by scholars, practitioners and religious leaders (Tommas-Cardo, 2019).

Whilst such beliefs have been found to be commonplace in British Muslims, so also are ideas that psychological experiences are related to social and environmental stressors or biological

phenomenon (Khalifa et al., 2011; Dein et al., 2008; Gunson et al., 2019; Ahmed; 2019; Manawar, 2017). However, conviction in these different conceptualisations lies on a spectrum. Non-dualistic Islamic models of mental illness have existed in Islamic societies since medieval times (Dolls, 1992).

Research has indicated a sense of concern and dissatisfaction from Muslim populations about how mainstream service could manage the dimensions of their beliefs and experiences which do not fit into Western bio-psycho-social paradigms but may be essential to their identity. However, this research has also shown that these populations would like mainstream services to incorporate different understanding of mental health (Rethink, 2007; Ahmed; 2019). Currently, these populations may seek religious interventions or family and community support over professionals and mainstream mental health services in order to access support which is sensitive to their needs (Weatherhead & Daiches, 2010; Khalifa et al., 2011; Ahmed, 2019; Gunson et al., 2019).

#### 1.5.6 Epistemic Injustice and Epistemic Racism

Research with mental health workers has often highlighted their lack of understanding of how to work with the religious or cultural conceptualisations of mental health held by Muslims, often meaning that treatment is informed by the salient western models available to professionals, rather than the provision of culturally appropriate care (Manawar, 2017; Mir & Sheikh, 2010).

The prioritisation of Western models may be important to understand as a form of what Fricker (2007) termed 'epistemic injustice', whereby there is an inequality experienced by those with non-western or spiritual conceptualisation of distress, as their frameworks are marginalised by the domination of a universally applied Western standard, which does not consider and respond to different needs. *Hermeneutical injustice*<sup>6</sup> occurs due to the gap in social knowledge about the varying needs of different Muslim populations, caused by the essentialising of their differences and the prioritisation of Western frameworks; leading to the provision of culturally inappropriate care. However, *testimonial injustice*<sup>7</sup> also arises, due to

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<sup>6</sup> 'Hermeneutical injustice' is defined as "the injustice of having some significant area of one's social experience obscured from collective understanding owing to a structural prejudice in the collective hermeneutical resource" (Fricker, 2006).

<sup>7</sup> 'Testimonial injustice' is defines as the process in which "prejudice causes a hearer to give a speaker less credibility than she otherwise would" (Fricker, 2006).

the prejudice and discrimination facing Islam, whereby colonial, orientalist narratives about Islam may mean that their conceptualisations and experiences are given less credibility, which then informs professionals' judgements on treatment options.

This links to the idea of 'epistemic racism' put forward by Grosfoguel and Mielants (2006) whereby the 'West' has historically assumed authority on describing the experiences and needs of Muslims, despite lacking knowledge about the real nature of Islamic societies. These authors point out that epistemic racism serves to legitimise the dismissal of Islamic thought and contribution as less credible, underdeveloped, or otherwise negative, as a symptom of the wider cultural hegemony of western superiority.

As Laird and colleagues point out, little is known about how the racialisation of Muslims impacts the access to healthcare and interventions by those affected by this racialisation (2007). However, what can be seen are possible indications of this in research, such as Pilkington and colleagues (2012) who consider 'levels of acculturation and education' as factors affecting access to psychological therapies, concluding that professionals should "further consider education about mental health for Muslim populations" (pg. 18). Inherent in such a conclusion is the need for the other to be educated to improve access to service, rather than to question what inherent biases may underly such conclusions or how culturally aware services are.

Very little research appears to centre on how what epistemologies and frameworks services, professionals or researchers are adhering to when considering Islam or working with Muslims or racialised Muslims. Responsibility for lower levels of access is located in these communities (e.g. as 'hard to reach'), rather than in services.

## **1.6 Professional Judgements**

There is a dearth of literature examining factors that affect mental health professional's judgements and decisions in providing mental health care despite the power held by mental health professionals in society. What is available will be summarised here.

### 1.6.1 Research on Factors Affecting Mental Health Professionals' Judgements

Research conducted by O'Connor and Vandenberg (2005) in the United States, looked into the way that mental health professionals derived judgements about psychopathology when assessing religious beliefs. Their research found that Christian beliefs, that were more prominent in the U.S context, were judged to be significantly less delusional than beliefs derived from the less prominent Mormon religion; which itself was assessed as less delusional than the least prominent religion, the Nation of Islam. Identifying these beliefs as religious only reduced the rating of pathology for Christianity and Mormonism, but not for the Nation of Islam. The authors point out that despite diagnostic manuals addressing the need to consider religious and cultural norms in assessment of mental illness, this was applied selectively. When conducting the study with a non-professional participant group, they found near identical findings, suggestive that judgments on psychopathology may be based on the conventionality or social acceptance of the religion or the belief in relation to majority culture of the professional, rather than on the clinically appropriate decision (O'Connor & Vandenberg, 2010).

O'Connor and Vandenberg discuss the importance of these findings when contextualising the Nation of Islam as a religion with followers who are predominantly Black or 'African American', considering whether this may link to the overrepresentation of these ethnic groups in psychotic diagnoses, through the pathologising of their difference. Such findings have led other researchers to question how western professionals may interact with religions which are seen as 'other', like Islam, in their clinical practice (Colgan, 2015).

#### *1.6.1.1 Psychiatrists:*

Colgan's (2015) study interviewed 5 psychiatrists in the UK about their understanding of Islamic religious beliefs when conducting psychiatric assessments for psychosis. This research found that psychiatrists emphasised risk and case management considerations in their decision making, with exploration of religious beliefs not being seen a priority in the task of psychiatric assessment, due to constraints in managing high workloads in the NHS. However, Colgan found that the psychiatrists "gut feeling" that beliefs sounded "bizarre" informed their case management. Whilst recognising that coming from a different cultural or ethnic background as a service user may lead to inaccurate understanding of their experience, psychiatrists were still found to associate religious beliefs with pathology. However, these findings are limited in their generalisability due to the number of participants interviewed.

#### *1.6.1.2 Psychologists:*

Research by Jackson and Coyle similarly analysed interview data with 11 therapists, including clinical and counselling psychologists as well as psychotherapists about their experiences working with different spiritual or religious beliefs (2009). They found that spiritual or religious beliefs were often considered by therapists with regards to their psychological properties or functions; often constructing religious beliefs as ‘psychic defenses’. They also found the idea of incompatibility between spiritual beliefs and psychotherapy was common and that therapists often termed beliefs with regards to their psychological ‘helpfulness’; sometimes expressing a need to change these beliefs to gain therapeutic benefit. This research pointed out the large influence that therapists’ own paradigms, both professional and personal, had on their approach to patients’ spiritual beliefs and psychological needs.

#### *1.6.1.3 Mental Health Nurses:*

Eeles, Lowe and Wellman (2003) conducted research with 14 mental health nurses to examine their assessments of pathology when evaluating vignettes of spiritual-type experiences. They found that nurses used their own ideas on what is possible or plausible and evaluated spiritual-type experiences that fell outside of these limits as pathological. In making sense of the spiritual-type experiences, nurses used psychological and biomedical/diagnostic interpretations of what had caused the experience. However, nurses also felt that it was important to understand whether a spiritual-type experiences was normal within the person’s cultural frame of reference and how people from the same or similar religious or cultural background would understand it.

Such research indicates variations within different mental health professionals in the way that conventional cultural ideas and professional frameworks are utilised in forming judgements about service users’ beliefs and psychopathology.

### 1.6.2 Professional Judgements and ‘Muslims’

#### *1.6.2.1 Literature search:*

Having considered the wider literature on research on what factors may inform mental health professionals’ judgements toward religious beliefs, a literature review was conducted looking



specifically at what informed health professionals' judgements about Islam, when encountered in clinical practice in the UK.

Literature searches were conducted on three online databases: EBSCO (Academic Search Complete, CINAHL Plus and PsycINFO), Science Direct and SCOPUS. Research identified as relevant was based in the UK and explicitly examined professionals' experiences of working with Muslim service users or discussing Islam. A detailed outline of the search strategies and inclusion criteria used to derive appropriate literature can be found in Appendix A. Of the papers reviewed, 9 studies were felt to match the inclusion criteria; these papers will now be summarised.

#### *1.6.2.2 Summary of literature:*

Research by Hassan and colleagues interviewed a range healthcare providers of maternity care to Muslim women (2020). Their research found that professionals often expressed stereotypical beliefs about Muslim women, including 'concerns' about the extent to which they felt Muslim women made their own decisions, describing them as shy. They also expressed difficulty in working with women who showed a perceived 'inflexibility' in their beliefs and when they perceived beliefs in 'fate' to be an obstacle for some women in making decisions about treatments which professionals had felt were essential to make (e.g. whether to have a caesarean section). Their knowledge of Islamic practices also appeared more prominent in more typically understood practices, such as covering up parts of the body, and less familiar with practices such as prayer recitals.

Research with mental health professionals working in Inpatient services in London similarly found participants expressing ideas about the perceived subordinated position of women in Islam, as well as confusion about religious practices (Jadhav, 2004). These participants showed some understanding of the needs of Muslim patient groups, however the authors highlight the need for an individual and intersectional approach by ensuring Muslims are asked about their own personal beliefs and needs rather than making assumptions simply on the basis of their faith identity.

#### *1.6.2.3 Impact on care:*

Whilst these studies could not show the impact of these professionals' beliefs on their judgments and actions, Mir and Sheikh's research observed interactions with both physical

and mental health professionals with Muslim patients (2010). They found a discrepancy in the accounts and understanding of these healthcare interactions between professionals and service users. Professionals often cited stereotypical beliefs about women's subordination or ideas of 'fatalism' which informed the way professionals understood patients' disengagement or non-compliance with treatment. However, patients' accounts of the same interactions showed these judgements to be inaccurate, neglecting important information about their needs through these misinformed assumptions. These misjudgements were seen to cause delays in treatment and punitive decision making.

Worth and colleagues noted a hesitation in professionals to consider and address cultural needs in providing end of life care to South Asian Muslims and Sikhs (2009). These professionals expressed a lack of understanding about many of the cultural or religious needs of this population, as well as struggles in teams in how to integrate those needs with practice, for example whether to allow family members to provide interventions that the nurses were responsible for. Professionals expressed worries about their cultural competence and a 'fear of getting it wrong'. The researchers argued that the resultant insufficiencies in providing end of life care to ethnic and religious minorities contributed to institutional racism.

Burr (2002) found that, when working with South Asian women, mental health professionals constructed cultural differences as fixed and immutable and these constructs were built upon orientalist stereotypes. These racist stereotypes impacted on professionals' judgments as patients were given the option of either taking the care that was offered or being excluded from services. Mistry and colleagues similarly noted some professionals communicating that they felt unable to assess or treat a Muslim woman wearing the Niqab, if the request to take the veil off is declined (2009). Interestingly, a number of UK based professionals in this study declined for their data to be included in the reporting of the study's finding, which was linked by the authors to the socio-political narratives about whether or not to ban the niqab in the UK that were occurring at that time.

#### *1.6.2.4 Western hegemony and professional judgments of Islam:*

Research by Laird, De Marrais and Barnes used content analysis to review over 2000 medical research articles between 1966-2005 for their portrayal of Islam and Muslims (2007). They found that the medical literature frequently reproduced orientalist and colonial discourses. This research painted Muslims as both in particular 'need' of biomedical western education

and intervention and ‘modernity’, whilst also portraying Islam as a barrier to healthcare delivery due to the negative effects of ‘tradition’. Many studies researched the health ‘effects’ of Islamic practices such as going to *hajj*, fasting or identified beliefs in supernatural causes as requiring ‘mental health education’. These authors raise the importance of considering research critically and understanding the role that it plays in reproducing misinformed discourses of Muslims and maintaining structural inequalities in service provision

#### *1.6.2.5 The impact of PREVENT on professionals’ judgements:*

Research by Younis and Jadhav studied Islamophobia with the NHS through observing and interviewing attendees of PREVENT training (2019a). They found that professionals were asked to rely on their intuitions when considering service users’ risk of radicalisation. However, the discourses around the threat of ‘Islamic Terrorism’, which underpinned the creation of the PREVENT policy, were underemphasised in the training, yet stayed salient in the professionals’ minds. Their research provided examples of professionals experiencing alarm when racialised Muslims engaged in behaviour that may not otherwise be considered alarming if carried out by a ‘White, middle class’ person, such as home-schooling children or choosing to cover their hair. The authors suggest that the statutory nature of the Prevent duty gives prejudicial thoughts institutional and clinical legitimacy.

Younis and Jadhav also noted a self-censoring occurring in professionals who are critical of PREVENT yet feel duty bound to fulfil their professional obligation to incorporate PREVENT policy practice. Furthermore, the incessant overworking, common in the NHS, led to apathy and uncritical compliance in professionals (Younis & Jadhav, 2019b).

Kovandžić and colleagues conclude from their research with professionals, local Somali community members and third sector workers, that to provide appropriate care, mental health services needed to adopt a localised approach which de-centralised professional paradigms to create a ‘space of access’ to diverse forms of support (2012).

## **1.7 Rationale for Current Study**

Some research has indicated that professional judgements about religious beliefs are impacted by dominant cultural ideas and the social positioning of a religion within a given context. Research looking specifically at professionals working with Muslims has noted the

presence of stereotypes about Islam and an uncertainty from professionals in how to work with Islamic cultural or religious beliefs. However, this research is limited and much of the wider research looking into the underutilisation of mental health services by Muslim populations has focussed on perceived barriers that exist within Muslim communities.

Given the current socio-political positioning of Islam and the way that professional, social and personal contexts have been seen to shape mental health approaches and professional judgements, there is a need to examine the way professionals come to think about Islam and how this might contribute to Muslim service users' utilisation and experience of mental health services. This study utilises rich data from interviews with a range of mental health professionals to explore what influences the way professionals construct Islam and whether these constructs go on to affect their clinical judgements and decisions when working with Muslims.

#### 1.7.1 Research Questions

1. What discourses do mental health professionals draw on when encountering Islam, Muslims or racialised 'Muslims'.
2. Has this interacted with their clinical judgements, decisions and practice?
3. What influence do the epistemological position, training and diversity of professions have on practitioners?

## **2. METHOD**

This chapter outlines the methodology underlying this research, including a discussion of the ontological assumptions and epistemological position of the researcher. Consideration for taking a *critical realist* position will be outlined and the use of a qualitative methodology, utilising interview data analysed with Thematic Analysis (TA) will then be justified as consistent with this philosophical position.

The chapter will then outline the methods and procedures used to approach this research, including considerations about research ethics and how recruitment, interviews, and thematic analysis were carried out.

The chapter will end with reflections on how aspects of my identity, social positioning and associated values and experiences may have influenced my approach to this research process.

## **2.1 Methodology**

Methodology is the framework guiding how research will be conducted; such as what methods will be used to collect specific types of data and how this will be analysed (Chamberlain, 2015). Carter and Little (2007) outline the importance of identifying the daily assumptions and principles held by all researchers, as they are seen to inevitably influence research agendas, practice and findings. Methodological awareness therefore carries substantial benefit.

Crotty (1998) outlines four basic elements to any research process:

- What methods do we propose to use to gather and analyse data?
- What methodology governs our choice of methods?
- What theoretical perspective underlies our methodology?
- What epistemology informs our theoretical perspective?

As noted by Crotty, to understand the theoretical perspectives which underpin our methodology, an understanding of our epistemological position must be explored. This research is now discussed with consideration of these basic elements of research in mind.

## **2.2 Epistemology and Ontology**

### **2.2.1 Critical Realism**

This research is interested in the constructions that are made about the religion of Islam and therefore invests to some degree in relativist ideas about reality. However, this research seeks to root these constructs into their social and cultural context and in so doing assumes there is a social reality in which phenomenon such as ‘Islamophobia’, ‘Orientalism’ and ‘Colonialism’ may be identified. These are assumed to be evidenced by real world, knowable

events or consequences that Western socio-political discourses have had on the life experiences of ‘Muslims’, for example, through experiences of hate crimes or through disparities seen in access to social resources, noted in this population. Therefore, there is an ontological realism held about these social processes, however, epistemologically, a relativist position is considered in how these processes may be differently considered by professionals.

Critical realism suggests that some reality does exist independent of human knowledge about it (Bhaskar, 1978), which supports ontological realism. However, our understanding of this reality can only ever be partially known, as our understanding is mediated by our socially located knowledge and experience (Braun & Clarke, 2013). Critical realism suggests that we may attempt to develop our understanding of the world through theories and research (Danermark et al., 2002), whilst recognising that these understandings need to be contextualised to subjective or social factors which have been part of the construction of that ‘knowledge’. In this sense it is closer to epistemic relativism, treating the world as theory-laden, but not theory-determined. These theories are thought to help us get closer to an understanding of reality through the use of *rational judgment*, a criterion for judging which accounts about the world are better or worse, whilst acknowledging that not all accounts are created equally. It requires researchers to adjudicate between opposing or counteracting accounts and therefore makes it a useful tool for considering issues of social injustice and considering solutions for social change (Fletcher, 2017).

Pilgrim (2014, 2020) highlights how the combination of ontological realism, epistemological relativism and judgemental rationality give critical realism a distinctive position in research; whereby researchers can attend to both the constructed experiences of events and the non-discursive realities or social context in which these constructions occur; which may in turn limit or influence constructed realities.

Critical realism permits the researcher to go further than the different accounts given by people and considers what wider support or evidence is available in determining which way to best understand a social phenomenon (Harper, 2012). This position compliments this research as it allows for an explorative approach to consider how Islam is constructed, whilst also permitting these constructs to be analysed against assumed knowable social processes, such as Islamophobia, which are afforded ontological reality and can therefore be studied and

scrutinised. Theoretical perspectives and evidence from scholarly works in postcolonialism and critical race theory could therefore be drawn upon in the process of rational judgement.

It is important to maintain consistency between the epistemological position and aims of the research and the methods used for data collection and analysis (Chamberlin, 2015, pg. 24), therefore consideration of the research design and method of data analysis is now considered.

## **2.3 Qualitative Research**

Qualitative methodology provides researcher the opportunity to obtain rich descriptions about the phenomena which is of research interest (Harper, 2012). It can help capture less tangible factors, such as people's complex and situated behaviour, practices and beliefs (Rohleder & Lyons, 2014). Gaining a rich understanding about a specific social context or phenomenon is sought and prioritised, rather than pursuits of broad, generalisable data findings to apply across contexts and populations. Given the dearth of literature exploring factors which influence professionals' judgements about Islam, this research seeks to capture rich data from which to consider the nuances in how constructs are created about Islam amongst different mental health professionals.

Different qualitative methodologies are available for undertaking such considerations, each emerging from distinct epistemological positions (Willig, 2013). Given the critical realist position adopted in this research, Thematic Analysis is one methodology that could be used to analyse this study's data.

## **2.4 Critical Realist Thematic Analysis**

### **2.4.1 Thematic Analysis**

Thematic analysis is an exploratory method of data analysis which can be deployed to identify themes or patterns within data sets (Braun & Clarke, 2006). In this way it is independent of epistemology and theoretical position, as it can be utilised flexibly based on the research methodology. However, Braun and Clarke are clear to note that despite the flexibility of applying TA, it cannot be applied 'theory-less'; instead, researchers are required to be transparent about their epistemological positions and what assumptions are inherent in the research aims and design.

Thematic analysis was therefore utilised in this research from a critical realist position. Due to the dearth in literature about how professionals construct Islam in their practice, much of the data obtained was detailed and exploratory and therefore an inductive approach to thematic analysis was taken. TA provides a framework from which this rich data could be structured and organised into themes; whilst allowing for these themes to be drawn upon using both relativist and realist ideas.

#### 2.4.2 Considering Different Analyses

Using Foucauldian ideas of discourse in analysis was considered for this research, due to the sociocultural roots of assumed knowledge about Islam and ‘Muslims’ in the West.

Foucauldian Discourse Analysis (FDA) is a method of data analysis concerned with identifying ideologies and the inherent power structures within our shared discourses and critically deconstructing these from the language that people use when speaking about a topic. FDA may have enabled me to explore the discourses that professionals drew upon when constructing their ideas about Islam and Muslims in their clinical experiences and what possibilities this left them in terms of their practice (Willig, 2013). However, this research was also interested in considering why different professionals may use some constructions over others in forming their constructions of Islam (Burr, 2003) and what impact extra-discursive, or material practices<sup>8</sup> may have on the discursive, or on which discourses are more or less easily enabled by different professionals (Willig, 1999; Sims-Schouten et al., 2007).

Therefore, an inductive, critical realist thematic analysis was felt to be appropriate than FDA in allowing the research to look beyond discourse and subject positions (Braun & Clarke, 2020) allowing for a diverse range of themes to emerge from the data set, capturing variations and similarities across professionals’ subjective accounts (Braun & Clarke, 2013). These could be analysed in relation to both what was said by professionals (including what

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<sup>8</sup> Extra-discursive factors are considered to be material structures or practices that exist independently of our understanding or awareness of them (Bhasker, 1989). These are underlying, relatively enduring, structures which may be biochemical (e.g. embodied factors see. Cromby & Nightingale, 1999), economic or social, and can go on to impact on the discursive (Willig, 1999).

Material practices can be produced by discourse practices, making ‘social facts’ ontologically real things which have the power to influence how a person thinks and behaves (Durkheim, 1964; pg. 52).



discourses they drew upon in constructing Islam and Muslims), whilst also considering what factors might influence the discourse they drew upon on and including how material practices (e.g. statutory duties, access to training or material resources) may be negotiated in forming these constructed realities.

This contextualisation was felt to be important given the sensitivity of discussing Islam in the current UK context and to protect the professional integrity of participants by situating their views and practices within their institutionally constructed and materially reinforced social contexts, reducing the propensity for inappropriate 'blame' to professionals on issues with much more systematic causes (Sims-Schouten et al., 2007; Younis and Jadhav, 2019a).

This research therefore provided a critical realist thematic analysis, to consider the ways that mental health professionals may differently engage with dominant discourses about Islam in the West and whether this can be seen as reflected in their clinical practice.

## **2.5 Methods- Design and Procedure**

### 2.5.1 Ethical Considerations

Ethical approval for this study was given by the University of East London's School of Psychology Research and Ethics Committee (Appendix B). This was sought to ensure that the research design met the moral and ethical requirements of the Code of Human Research Ethics (2016), as outlined by the British Psychology Society.

Consideration was given to ensuring informed consent was obtained from participants taking part in the research. An information sheet (Appendix C) was provided outlining the research aims, what participation would involve and how participants' data would be used and disseminated. This outlined issues of confidentiality, including ensuring anonymity in the research process and any dissemination of the findings. This also included information about data security. This was all communicated in accessible terms to ensure participants' consent was informed. Participants were also given the opportunity to enquire further about the research or research process.

The participants' right to not feel coerced into this study was made explicit and their right to withdraw from the study at any time before data analysis was outlined. The fixed date of 1<sup>st</sup>

January 2020 was provided for data analysis, however, for the minority of interviews which occurred close to or after this date, this window was extended to 1<sup>st</sup> March 2020. The consent form was amended in these instances.

Consent was obtained using a signed consent form (Appendix D). This confirmed that participants had been given the information highlighted above about the study, understood what participation would involve and how their data would be used and confirmation of their consent to participate in the research; with the awareness of their right to withdraw before data analysis had been undertaken.

Participants were explicitly reassured that there would be no negative consequences should they withdraw from the research and were reminded after interview of their right to withdraw consent, with respect to the possibility that the interview may have elicited things that had not been initially considered.

A Debrief Form (Appendix E) was also provided to participants following their participation, with further details about the study and a reminder about what will happen to their data, their right to withdraw and contact details should they wish to discuss the research with the researcher or research supervisor.

#### *2.5.1.1 Potential for Distress:*

Whilst no anticipated risk of harm to participants was identified, I was aware of the politicisation of Islam and the narratives about Islamophobia present in current socio-political consciousness may make this a sensitive topic of discussion. Some research has identified the impact that these issues have had on participants wanting to include their data involving discussions about Islam, into research (Mistry et al., 2009). Smith and colleagues (2009, p. 53) view that “simply talking about sensitive issues might constitute ‘harm’”. With such considerations in mind I was conscious to consider and respond to any signs of distress emerging from the interview process. However, this also needed considering with regards to the data analysis and how participants may feel about the interpretations made about their words. Taking an inductive approach to analysis was used to support this process, ensuring participants words were not decontextualised and reflected what they had said. Furthermore, interpretations participants words into wider social discourses helped to situate what was said

into contextual factors, in order to give justice to the impact that such contexts may have on participants' constructions of Islam.

### 2.5.2 Recruitment

This research recruited mental health professionals from three main professions: Clinical Psychology, Psychiatry and Mental Health Nursing. These professions were chosen as they represent three of the most common professions in the mental health workforce (King's Fund, 2015). Furthermore, differences were noted in the literature search about the way that these different professions conceptualise mental health and how this informs mental health intervention. Differences were also noted in the religious and cultural diversity within these professions, which was considered as influential in how professionals formed their judgements.

Inclusion criteria included:

- Practising as either a qualified clinical psychologist, mental health nurse or psychiatry specialty doctor in the UK.
- Identifying as having had direct clinical experience of working with Islam or Muslim service users in their clinical practice.

By default, all participant were over the age of 18 and spoke English, due to the entry requirements for their UK qualifications and practice in their respective role. No specific amount of experience working with 'Muslims' was required, in order to allow inclusivity for a range of professionals' levels of engagement with Islam or 'Muslims'. There were no specific age, gender, ethnicity, or religious targets for recruitment, however consideration was given to ensuring that overrepresentation of any specific demographic, which was not reflective of the makeup of a profession, was minimised.

This research utilised social media networks to recruit participants. A research poster (Appendix F) was made to advertise the project. This was shared in mental health professionals' groups, such as 'UK based Clinical Psychologists Network' on Facebook and equivalent groups for Psychiatry and Mental Health Nursing. Professionals in my own informal network were also made aware of this study through social media and shared this through their own informal networks, reaching many professionals through a snowballing

effect. Participants who expressed interest in the study were then sent the study information sheet via email.

Information was gathered from people who showed interest in the study (Appendix G) and where there was the option, participants were selected based on maximising the variety in factors such as ethnicity, area of mental health worked in, years of experience, religious or spiritual beliefs and experience considering the issues presented in the research study.

### 2.5.3 Participants

Twelve participants were recruited to the study, 4 participants representing each of the three professions. However, due to the Covid-19 pandemic, one mental health nurse participant withdrew from participation due to unforeseen circumstances. Further recruitment was sought at this point however the immediacy of Covid-19 pressures meant that several potential participants needed to delay participation. Timescales of this research submission meant that this additional participant could no longer be facilitated.

In total 11 interviews were carried out; 4 clinical psychologists, 4 psychiatry speciality trainees and 3 mental health nurses. Most participants worked with NHS services in London however one participant worked in NHS services in the midlands and one in the Oxford region. A table of demographics can be found in Appendix H.

### 2.5.4 Interviews

Interviews are the most common qualitative method of data collection and are noted to be useful for exploring people's understandings, perceptions and constructions of a given topic (Braun & Clarke, 2013, pg. 77-81). A semi structured interview was utilised in this research, adopting an interview guide (Appendix. I) which was used flexibly to allow a responsive approach to participants' developing accounts of their experiences of encountering Islam. This was taken in in order to facilitate the diverse and unique contributions participants may bring to the interview topic. These interviews were conducted either face to face or over Skype. Whilst face to face interviews are seen as preferable (Novick, 2008), Skype interviews were offered in order to facilitate convenience to participants, as this research could not reimburse them for their time. Interviews lasted between 30-40 minutes.

#### *2.5.4.1 Interview schedule:*

The semi structured interview schedule was informed by the literature search outlined in Chapter 1. This began with an exploration about how Islam was identified by professionals, in order to explore the racialisation of Islam and what factors or identities are, or are not, considered in the construction of Islam. The schedule then considers how professionals construct the relationship between Islamic identities, beliefs or practices<sup>9</sup> and mental health and whether their clinical approaches of professionals were affected by service users' Islamic identities, beliefs and practices. Professionals were then asked about how they related to these encounters in relation to their own personal and professional identities, beliefs and practices; what resources they have utilised in their work when encountering Islam; and whether there were resources they have felt they further required. These questions were structured in this way to initially capture concrete constructions of Islam before asking participants to engage in self-reflective interactions between themselves and Islam; which may potentially lead to more defensive, intellectual or theoretical constructions, due to its reference to their professional work. Probes and pauses were used throughout the interview process, particularly when it was considered helpful to encourage participants when socially desirable, vague and hesitant responses were indicated; to allow for more useful data to be obtained (Fielding & Thomas, 2008; Ryan, Coughlan & Cronin, 2009).

Interviews were audio recorded to allow for later transcription freeing the researcher to engage responsively to the interview process.

#### 2.5.5 Resources

A digital audio recorder was used to record the interviews and these data files were transferred to a secure password-protected computer hardware. A mobile phone was utilised with study specific SIM card, to allow participants telephone and email access to the researcher. Skype was used for virtual interviews, incurring no cost. Face to face interviews were undertaken at participant's place of work, at their request. Participation was voluntary and no additional costs were incurred on travel.

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<sup>9</sup> The differentiation between identities, beliefs and practices have been made to allow inclusivity for the many ways that constructions of Islam may be grounded (e.g. the performance of Islam through affiliated religious practices or the affiliation of an Islamic identity through ethnicity or culture). Furthermore, this differentiation pays respect to the diversity of Islamic 'identities' and the beliefs and practices that are associated with these.

### 2.5.6 Transcription

Interview data was manually transcribed in preparation for data analysis and was part of familiarising with the data, the first stage of thematic analysis. The interviews were transcribed using an orthographic style (verbatim) in order to ensure the original words of participants were available for an inductive analysis. However, transcripts are anonymised, and participants are allocated unique participant identification number. Other identifiable information is also omitted, replaced with generic descriptions. Sentence structures, non-semantic sounds, hesitations, repetitions, pauses and other such occurrences have been kept as close as possible to their appearance within the interview; although such judgement are subject to the researcher's interpretation.

This simple, yet thorough, transcribing method is used to compliment the critical realist epistemological position of the research; providing sufficient detail to allow for some level of patterned or meaningful response to be induced from within the data, whilst acknowledging the subjective process in which the data will interact with my own judgement and deduction of themes (Braun and Clarke, 2006, pg. 169). The transcription convention utilised for presenting extracts of the data in the Results chapter can be found in Appendix J.

### 2.5.7 Thematic Analysis Procedure

The transcripts will be analysed using Braun and Clarke's (2006) six-phase approach to thematic analysis. Whilst outlined as a linear process, this will be approached recursively, as intended by the authors, to strengthen the development of themes through the process of analysis.

The six-phases included:

#### Phase 1. Familiarisation with the data:

The researcher familiarised themselves with the interview data by keeping notes at different points of interacting with the data. This included making notes after each interview of distinctive features after re-listening to the interview, during the transcription process and after casual reading of the transcripts. These initial observations included consideration of both the manifest and latent content to what participant's had discussed about Islam, what they said, what may underlie this and what was unsaid.

## Phase 2. Generating Initial Codes

With consideration of the research questions, both descriptive and interpretive codes were generated from the data. Summaries were made, keeping close to the language and concepts used by participants. However, the words and meanings of participants were also considered critically to form interpretive codes, based on the authors terms of reference in the research area, which may be interpreted as representing latent themes, such as ‘Orientalist narratives. A list of Initial themes may be found in Appendix K and an example extract of a coded transcript can be found in Appendix L.

## Phase 3. Searching for Themes

These codes were used to build themes, which acted as central organising concepts that captured “something important about the data in relation to the research question, and represents some level of patterned responses or meaning within the data set” (Braun and Clarke, 2006, p. 82). Relevant literature was considered with regards to emerging themes about the construction of Islam in the West, as well as the inter-professional similarities and differences noted in interacting with Islam.

A thematic map was produced (Appendix M) in order to highlight these candidate themes, sub themes and their relation to one another.

## Phase 4. Reviewing Potential Themes

Candidate themes were then reviewed by considering them in relation to the related codes and extracted transcript data to ensure that they are coherent. Adjustments were made in this recursive process to ensure themes were thick and data rich, providing helpful information relating to the research questions and the data set. The breakdown of refining candidate themes into the final themes can be found in Appendix N, along with the final thematic map.

## Phase 5. Defining and Naming Themes

This phase involved providing a refined and detailed analysis of each theme, encompassing the unique essence of each theme, highlighted by extracts from the data. This provided both descriptions of themes as well as interpretation of these in relation to the research questions,

including an analysis of the connections between themes. A coding framework was produced listing Themes, Sub-themes and codes with their related extracts (Appendix O) and a table defining the themes and their relation to the research question can be found in Appendix P.

## Phase 6. Producing the Report

This phase involved the refining of this recursive process of data analysis and writing into a clear and coherent report of the data, which considered the way that the emergent themes were embedded into the area of research and the research questions; making explicit links to excerpts within the data. This is reported through the Results and Discussion chapters below.

## 2.6 Researcher's Positioning

As noted above, qualitative researchers have increasingly indicated the need to address what assumptions, epistemologies and world views researchers are bringing to their research. Lazard and McAvoy (2020) highlight the need to unpack the partial, positioned and affective perspectives we bring to the research, in order to allow our questioning to move beyond our taken-for-granted ways of making sense of the social world. These considerations are especially important for critical realist research (Bhaskar, 1978; Willig, 2013).

My identity as a British-Arab woman has meant that my racialised experiences hold a proximity to this research topic and influence my positioning and motivations in the undertaking of this research. My experiences of growing up exposed to both Middle Eastern and Western culture often involved a sense of dissonance between how Arabs, Muslims and Islam were constructed and discussed in this western context and my own person experiences and constructs of what these things meant. Such experiences likely influenced my interest in epistemologically relativist approaches to research, given the vastly differing perspectives I have been exposed to and had to learn to navigate from an early age. My adoption of a critical realist perspective may be understood as rooted in the consequences that these socio-political contexts and hegemonic discourses have had on my lived reality. My motivation for this research and issues of social justice are then closely linked to my identification with other peoples' experiences of intersectional marginalisation and disadvantage in access to



social resources, or culturally relevant and appropriate frameworks from which to understand their experiences.

However, I am critically aware that my experiences and subsequent relation to these topics are by no means definitive of the vast range of 'Arab' or 'Muslim' experiences and ideas that exist in the West, or further afield. My privileges, as a British citizen, who is a doctoral level educated trainee clinical psychologist, and the socioeconomic advantage associated with this, provide me with access to power and a role in the process of knowledge production in Western society. This may elevate my perspective over others'; therefore, it is important to state the range of ideas that may exist on these topics within these heterogenous identities.

My presence in the Western academic arena may be considered as a limitation on the form of knowledge that can be produced in this study. Reflecting throughout the process of this research, a common preoccupation has been whether the way that this research has been conducted, as an examined assessment in a Western, UK academic university context, has itself confined my approach to the research topic. This has included performing literature searches within largely Western academic journals, or having the research approved, supervised and assessed by predominantly white or Western academics. Whilst confining the literature to a UK context may have been important for identifying the most relevant literature for UK mental health experiences, it remains limited by the systems of power that operate within this context with regards to who contributes to the production of knowledge and which voices are absent or excluded. Grey literature or literature from postcolonial or critical race theorist were sought to support a critical perspective in analysing the available literature.

Keeping a reflective diary (Appendix Q) through this process, engaging with peers, colleagues and relevant research and literature have all supported this process of reflexivity. The adoption of a critical realist approach to thematic analysis provides me with a structure which can be utilised to attend to both the benefits and limitations of being personally close to a research topic. As a mental health professional and as a British-Arab I bring many biases and assumptions to the research. This methodology ensures transparency about the cultural frames from which I have interpreted the data acquired, whilst also balancing this with an inductive approach to data analysis that can help to ensure that the varied experiences and ideas of professionals will be developed from their talk, rather than from my own ideas. This

is important to consider given the relative power I have as a researcher in presenting and interpreting participants' contributions.

### 3. RESULTS

Interview data was analysed using thematic analysis and the coded transcripts were organised into 3 main themes with 13 corresponding sub-themes (see Appendix M. for full thematic map).

#### 3.1 Theme 1: Knowledge About Islam- Sources and Extent of Knowledge

In this theme, participants' accounts of the extent of their knowledge about Islam and the sources of that knowledge is provided. Six sub-themes emerged which illustrated the varying personal, professional and social experiences and influences which interact in forming mental health professions' understandings of Islam.

##### 3.1.1 Sub Theme 1: Lack of Exposure to Cultural Difference and its Effects

*P2: when I started nursing in (Northern Region in UK){...}we didn't have many other ethnic minorities or religions apart from white British generally, Christian mainly*

*P11: a kind of white area there was only one black girl in my year and but through the curriculum we were introduced to that [Islam]*

Some participants made reference to a lack of exposure to cultural and religious diversity during formative years of their personal or professional development. The centrality of white and Christian experience in the minds of the professionals interviewed may be indicated here; with exposure to Islam being mostly peripheral or indirect, such as through school education or the presence of a minority group within the local area.

*P5: in Britain{...}religion isn't that important to them and yet they get anchored in a Christian environment but they just don't notice it really because it's just so normal to them*

This was considered by a participant who expressed the overall lack of importance of religion in the UK, whilst acknowledging the implicit default Christian norm that acts as a familiar frame of reference in Britain when considering religion. These ideas may also be considered in relation to how Islam may be constructed as a non-white, non-western religion and as something unknown and ‘different’.

*P8: I kind of associated full coverage as something bad and I think until now, less now, I still find it strange{...}my culture in a way we have a very kind of you know open body exposed culture and freedom of expression*

*P3: when I see a woman wearing the full err headscarf it feels I don't kind of feel comfortable*

*I: What makes that difficult?*

*P3: because it's kind of very unusual to what I've been exposed to in my culture{...}I have kind of my own values about equality and about human right and erm I tend to treat women as equal human beings*

Participants talked about their exposure to ‘Muslim’ minorities in a way that highlighted comparative considerations of contrasting cultures, evident in participants’ reference to their own values and practices; incorporating constructs such as freedom and equality as being in apparent contrast to their perceptions of Islamic culture. Ideas of ‘normality’ were often based in professionals’ own cultures, highlighting Islam as different; however, similarities were also considered at times.

*P10: when they're talking about their faith I suppose because I'm a Christian I think about like what I believe in and there are some similarities*

*P8: in a way it was very similar to Christianity because yeah like one God one main book you know starting sort of in the Middle East*

The relatability of Islam being an Abrahamic religion, like Christianity, appeared to bridge this contrast somewhat and foster a sense of connection, rather than difference in some.

Other participants showed acknowledgement of how their own culture or position on religion might limit them in their understanding of Islam and their interactions with Muslims.

*P9: because I'm an atheist myself I suppose you know I can't really connect and relate fully to that idea of things being in God's hands and sort of um living by principles or things that have come from religious texts*

### 3.1.2 Sub-Theme 2: Experience of Cultural Difference and its Effects

This theme highlights the influence which some participants felt being exposed to multiculturalism or religious diversity had on their way of considering and interacting with 'difference'.

*P4: I grew up in quite a multicultural community so it's never crossed my mind that there's only one way to see things{...}you have to kind of learn about other people's beliefs*

*P11: I was brought up within a religion{...}seeing the diversity within Christianity and all the you know the reality of what that looks{...}you see behind the kind of projection behind the what people perceive it to be.*

Participants' experiences of encountering religious or cultural diversity, even within majority cultures such as Christianity, was felt to support their understandings of managing 'difference'. Insight into the misrepresentations held in superficial social knowledge about religion was also highlighted, from the perspective of Christianity.

Awareness of the difficulties faced by minority social groups in the UK was also considered

*P6: Well as someone...ethnically different from the majority of the population{...} I very much appreciate that there will be things experienced by this population group [Muslims] that the rest of the population who aren't this specific characteristic won't experience*

This participant belonging to a minority ethnic group appeared to identify with similarities in their own experiences and those of Muslims, recognising both the overt and covert processes in society which might contribute to marginalisation. Perhaps implicit in this is awareness of

the misconceptualisations about Islam in society and racialised discrimination affecting Muslims in the UK.

### 3.1.3 Sub-Theme 3: Specific Personal Experiences of Islam

Professionals also identified personal experience or encounters with Islam which they felt had contributed to their understanding of the religion; sometimes offering a different insight into the religion to the one they had.

*P1: my brother in law and his family are Muslim...those personal experiences that I think that you can't help kind of tying in*

*P6: I dated a girl who was from, who was Muslim and that's was what really gave me the insight...you get to experience something on more of a personal level*

The lack of such contact was also mentioned.

*P9: I was very aware of my lack of knowledge about their beliefs, I don't have any Muslim friends*

However, personal experience accounts did not include discussion of the impact that personal contact with Muslims had on their experience of Islam; what had changed and how. Other professionals with less personal contact took this up with regards to 'demystifying' Islam.

*P11: I did learn about Islam at school{...}so I think I also had been provided with some information that kind of perhaps also demystified something*

*P8: where I'm living now so is there's a lot of Islamic faith and I think kind of gradually I don't find it so strange or sort of 'us and them' in a way I think I have felt like that before*

*P5: spending time abroad{...}in Muslim countries maybe and having experienced how friendly people tend to be and how there's a whole different side to the sort of negative public perception*

These accounts made reference to mystifying or ‘othering’ narratives about Islam (e.g. ‘us and them’) and a ‘negative public perception’ of the religion pointing to their role in Western discourse.

#### 3.1.4 Sub-Theme 4: Influence of Training and Education

Professionals often talked about the role that their professional training or workplace experiences played in developing their understanding of Islam.

*P2: the patients to me have been my biggest resource in my career more than any institution or book or lecture*

*P10: resources in the sense of like patient contact really other than that I can't think of anything that was formal*

Participants communicated a reliance on Muslim service users for learning about Islam, due to the absence of such considerations in professional spaces.

*P10: even in training it was like one of our tasks{...}to be aware of like cultural differences and like religion{...}but I don't actually remember having any sort of like formal training about Islam*

Some professions, predominantly mental health nurses, noted an emphasis on religious and cultural care in their training, however, there appeared to be little specific information on Islam.

*P1: I don't think we do really have any specific training on kind of working with people from kind of different backgrounds or different cultures erm we have you know this kind of like quite generic advice about kind of being open minded*

*P2: I mean there's the diversity training{...}equality diversity which was a loada rubbish really it was just a task to fill in answers and the questions were stupid*

Consideration of religious or cultural factors therefore appeared generic and superficial, relying on professionals to adapt their approach in contact with a service user's specified needs.

This lack of specificity might explain why some professionals spoke about taking a non-specific approach when working with Islam.

*I: Would you say the presence of these Islamic beliefs or identities affected the way you worked with people?*

*P6: largely speaking I wouldn't say so...in terms of how I would treat them*

*P2: personally, as a nurse I didn't really change how I interacted with anybody religion wise or otherwise because not just Muslim faith or faith in general{...}you deal with the individual person whatever issues problems beliefs that person has*

Thus, religion might either be de-emphasised or treated in an individualised and generic manner. However, this unspecific approach to Islam, and religion more generally, was considered by the Muslim professional interviewed as reductive to the needs of service users.

*P7: so sometimes people will say things like I don't see colour or I don't see religion and I'm not necessarily convinced that that is helpful I think people need to be seen and heard {...} that kind of being like considered as equality in some kind of way but that maybe shuts down people experiences or opportunities to talk about them{...}its really that unintentional marginalisation that can happen*

From this Muslim participant's perspective, the lack of focus on religion could be seen as a form of marginalisation.

### 3.1.5 Sub-Theme 5: Stated Lack of Knowledge Despite Reporting Extensive Clinical Experience with Muslim Service Users

Despite professionals communicating a reliance on Muslim service users in informing their understanding of Islam, they sometimes cited a lack of knowledge about Islam.

*P10: I don't really know much about the religion and I mean to this day I'm still kind of thinking like what is it that that they do in in terms of like practising their faith {...} I'm kind of thinking like why don't I know more \*laughs\*...we do assess a lot of people with an Islamic background*

*P9: I've worked in services where there are lots of Muslim clients before{...}I suppose I had some understanding about kind of culture and tradition and festivals and things from that but they were very little children...we didn't have kind of high level conversations about it*

These professionals seemed to question their own lack of information about Islam, despite having had a lot of contact with the religion through service users. That this appeared to be a novel thought perhaps suggests a lack of emphasis on service users' religious beliefs in their care provision. Where mental health professionals reported more involvement of religious or cultural considerations in their work, a lack of knowledge was still reported, however this was acknowledged with service users.

*P5: because I'm very obviously a white western woman{...}it didn't matter so much that maybe I didn't know some of the things or I was a bit ignorant because people are then able to tell me{...}sort of expert of their own beliefs and again for some people I felt like that was quite empowering*

*P4:I have to educate myself because I don't come from an Islamic background...I have some understanding but definitely not enough{...}I often kind of make it quite clear that if I don't understand something then they have to explain that to me and not to assume things*

Discussing their lack of knowledge about Islam with Muslim service users appeared to mobilise professionals in their not knowing, whilst also leading to further reliance of Muslim service users for this information. This raises the question of how much general knowledge of Islam is needed for professionals.

### 3.1.6 Sub-Theme 6: Awareness of Racism and Prejudice

Many of the professional interviewed made reference to experiences of discrimination reported by Muslim service users, as well as Muslim colleagues.



*P4: a few patients of mine, especially ladies{...}they tell me that people actually start abusing them verbally shouting things sometimes physical assaults*

*P11: lots of people I was working with young men were stopped regularly by police{...} in fact my colleague got beaten up and I felt things were kind of so you know they were racist*

There was an awareness of an increased societal prejudice against Islam in the current UK context however reference to Islamophobia and wider considerations about what anti-Muslim discriminations encapsulates were not explicitly considered by any of the professionals interviewed. However, some professionals linked this discrimination to terrorism.

*P3: the terror attacks{...}it might be more difficult for people of this background to come to a specialist because they don't want to be exposed on this biased approach or attitude*

*P9: around the time that terrorist attacks happened...I remember thinking like having that question in mind do I raise it you know because she'd previously spoken about racism{...}you can see in certain papers and stuff the kind of messages coming out*

Professionals' consideration of the social climate surrounding Islam and the impact of this on service users' experiences appeared to focus mainly on their clinical contact with this and little was said about how this was responded to or discussed with service users.

*P4: ladies because they wear the headscarf it is quite easy to tell that what their religious beliefs were and they told me they were quite paranoid when they go out in public and see people looking at them and just be worried about racism yeah{... }so of course if they already have underlying anxiety problems or paranoid beliefs then that would make it worse I think*

*P1: I've also had patients who have quite severe anxiety and sometimes have anxious thoughts that kind of that might involve kind of racial....prejudices against them{...}a lot of the time that is kind of based in kind of past experiences that they have had and then they go on to kind of have many more anxious thoughts that maybe don't always amount to*

*anything{...}and that can kind of feeds into then them not being able to kind of engage with life*

Consideration of discrimination experiences as exacerbating mental health difficulties was highlighted by professionals as a way that they integrated discrimination experiences into their clinical understandings.

The Muslim professional interviewed disclosed their own personal experiences of Islamophobic prejudice.

*P7: I remember I had an experience on my first placement my supervisors said to me “oh I’m surprised you’re fasting I didn’t really think you were that stupid” and I didn’t really know what to say or what to do in that situation, because nobody really prepares you for that*

*P7: maybe I would have known what to do if there had been the support or it had been explicitly talked about.*

Their personal relatability to this experience may be seen as sensitising them to the role of explicit conversations about racialised discrimination and how to manage this in the provision of support.

### **3.3 Theme 2: Assumptions and Their Consequences**

This theme includes accounts where participants describe the assumptions they made about Muslim service users and the effects that these assumptions had on their professional practice. Assumptions about Islam were highlighted as being implicitly used as a basis from which clinical judgements were made. This was potentially problematic when Islam was constructed as an obstacle to mental health understanding and recovery or as conflicting with professional models of mental health.

#### **3.2.1 Sub-Theme 1: Assumptions Made on the Basis of Perceived Similarities and Differences with Muslim Service Users and their Families**

This sub-theme included participants' accounts where they discussed service users as different from, or similar to them on the basis of often visible differences and the implications of these on their professional practice.

*P3: ethnicity and sometimes it's just the surname or name that can makes me aware that there might be a non-British background{...}the way they are dressed up, traditional clothes, erm sometimes err language and I mean accent if they are not born here*

*P4: if their beliefs are not in line with what the religion is teaching them{...}for example things to do with sexuality or things like independence and having your own unique identity for young women{...}traditional values that they feel like they are violating*

*P8: what I was expecting is that because of the background (Middle Eastern Country) and maybe I see it is something more traditional or backwards*

*P11: other people that who are also Muslim who most who you know who don't have those views and they are much more or what I would see as more kind of progressive err you know different way of gender relationships*

Common assumptions about Islam included references to 'traditionality'. This 'traditionality' may be understood as being linked to a non-western, more religious 'Islam'. Connecting religious teachings to 'traditional values', especially in contrast with topic such as independence, sexual openness and women's roles in society, indicates the contrasting of a traditional Islam to 'Western' associated cultural ideas and values, which were viewed as a sign of 'progressivity'. The interpretation of the term 'traditional' as relating to a perceived inferiority or 'backwardness' was made more explicit by one participant, which may be worth considering with regards to the wider implications or associations of its use.

This idea of 'traditionality' also had gendered connotations.

*P1: you might see kind of a husband and wife together and the kind of relationship between the two of them might indicate something...where the husband's kind of spoken more for the woman*

*P9: the woman I saw would wear like traditional dress and so then I guess I had preconceptions about what that might mean{...}I think I was a bit tentative about at times about how explicit to be*

Ideas about male domination and female restriction in Islam were common and encountering women who are perceived as ‘traditional’, such as through their religious clothing, appeared to lead to assumptions about what could and could not be spoken about.

*P3: I wouldn't understand how I might be able to relate or to connect so when I see a woman wearing the full headscarf it feels...I don't kind of feel comfortable, I wouldn't feel comfortable if I can't see the face*

Implicit assumptions about the meaning of women wearing Islamic cultural or religious clothing may also be seen as provoking the professional's own values or ideas, eliciting feelings of discomfort, which in turn impacted on their ability to relate or connect with the service users. The activation of professionals' concern or values was similarly noted with regards to violent social practices.

*P8:some more closed these communities with more traditional values...I do think that you know there is I had some training in honour based violence and things like that so I think sometimes it can be a bit sort of negative the training will be kind of focusing on the negatives and maybe safeguarding issues*

*P11: I have worked with people that have fled from forced marriages and things like that which is all done in the name of religion or with religion as part of it but yeah I don't but I didn't see that as just religion actually and you know like any religion they can all be interpreted and viewed differently*

Reference to these risk-related violent practices emerged from discussing clinical experiences of working with Islam. Whilst the reality of their encounter with these practices with ‘Muslim’ services users can be considered, the racialised narratives around these practices may also be recognised, with ideas of traditionality, closedness or religiosity being associated with them. Whilst professionals showed some awareness of this, the implications that such

racialisation may have on professionals' understanding or approach to such practices, or towards perceived traditional, closed or religious communities may be important to consider.

The association of risk with Islamic cultural or religious factors was discussed more widely.

*P3: If they do something risk related to the religion for example if they fast and there is a medical condition which makes it dangerous but they still prefer fasting*

*P9: he would make some friends with people from the same country while he was out one day and these were adults and they'd then befriended him and invited him into their home and were giving him dinner{...}when he first told us about it we were all a bit like ooh is this a safeguarding issue{...}but again actually that was something that was really culturally appropriate for him*

The professional discourses and responsibilities around safeguarding and risk are apparent here and discomfort or uncertainty appears to be activated when encountering culturally unfamiliar practices, despite the being culturally normal to Muslim service users.

Consideration of how perceived 'Westernised' Muslim may be met with more familiarity and ease may lend further support for such interpretations.

*P11: some of them also brought up within British schools and British you know influence culture ideas...they could kind of hold two different views at the same time{...}I also worked with some of the parents as well who were first generation just and there was a difference*

*P8: there's some people that I've worked that were born here{...}they seemed quite open they've been working with other professionals*

Ideas of westernisation or being acculturated and educated to 'Western' ways of being or thinking was considered as advantageous and a sign of openness. This 'westernisation' appeared to also be linked with lower levels of religiosity. The positioning of these western or acculturated Muslims as more amenable to professionals appeared to bring a sense of ease.

### 3.2.2 Sub-Theme 2: Construction of Islamic Beliefs as Challenging Implicit Professional Norms

This subtheme considered professionals' accounts about Islamic beliefs or practices as being in contrast with elements of their professional approaches and the impact this had on their clinical practice.

*P8: it was a it was striking for me to how the family is involved... I didn't know what they were there for*

*P1: very strong kind of family dynamic in terms of them kind of protecting her and kind of wanting to communicate kind of for her*

Many participants noted a sense of collectivism, in relation to family or community involvement, in considering support systems when working with Muslim service users. However, this involvement was framed as potentially restricting in allowing individuals to express themselves and perhaps indicative of pathological family dynamics.

*P8: whenever there is in any religion whenever there is kind of strong family involvement and a lot of sort of dogmas I do get a bit wary because I do want to reach out to you know the person will live in the system and the families and all that but also you know we want to give space for the person to really express*

*P4: there was a young lady I saw in the past she was quite reluctant to come to therapy by herself...she needed to be accompanied by a man{...} I found that a bit challenging because then I couldn't have a one to one conversation with her*

This may be understood as reflecting a western individualism implicit in mental health practice, where the thoughts and understanding of an individual and access to their unique and individual experiences are seen as necessary and of priority. Similar ideas about individual agency may be also considered in relation to professionals' attitudes towards Islamic understanding of religious 'fate' or God's determination.

*P9: both of them would say things um that would imply a belief that it was out of their control that it was in God's hands so perhaps less sort of individual perspective*

*P10: I actually have a patient at the moment who explains everything that's been happening through the word of God...he finds lots of comfort in it*

*P5: they felt it was some sort of punishment or you know{...}I think that's then a little tricky I guess because you don't wanna take someone's belief system away but equally you don't want them to feel that amount of guilt*

Whilst acknowledging the comfort service users took from these understanding of their experiences, the deviation of such ideas from western frameworks were noted. This appeared to raise conflict in some professionals, with regards to whether they should aim to modify such beliefs which they themselves had perceived to be helpful or conducive to recovery.

Such ideas may have contributed to the construction of Islamic service users and their families as reluctant to understand a situation in 'mental health terms' and approach services.

*P1: people from kind of a Muslim backgrounds who I think it's taken a while to present to{...}I think there's maybe kind of a reluctance to actually kind of ask for help in the first place or to kind of assume that it can be kind of worked through or can solve this before kind of getting help*

*P6: her family wouldn't understand her mental health{...}didn't acknowledge that there are mental health problems that aren't in the realms of normality and require extra support and treatment*

These constructions situate service users' cultural or religious frameworks and beliefs as inhibitors to them receiving, what is deemed by professionals to be, appropriate mental health care.

*P8: it's a strange expression is that person is not psychologically minded {...}I started hearing that more especially coming from specialist trauma services{...}it was more you know some cultural aspects they kind of know they want some attention some help but they just not gonna engage with the with something that is a bit more explorative and going into*

*the individual{...}a lot of psychologists and psychology services really struggled and couldn't really work with most of these clients*

***P3:** I would be less surprised perhaps if I offer psychotherapy or family therapy to a very religious family, I would be less surprised if they refused this offer and perhaps I wouldn't be very insistent{...}I kind of accepted this position more willingly than non- religious families*

Ideas such as 'psychological-mindedness' may be used to explain the perceived incompatibility or ineffectivity of western mental health approaches with Muslim service users, locating the problem in service users, their families and their cultural and religious beliefs. However, some indication of what professionals may contribute to the underrepresentation of Muslim service users in particular services may also be seen as hinted at by these professionals.

### 3.2.3 Sub-Theme 3: Perception of a Conflict or Tension Between Professional Models and Islamic Religious Beliefs or Culture

Participants also pointed to perceived incompatibilities or tensions between professional models of working and perceived Islamic religious and cultural factors. This included ideas of Islamic religious beliefs as being restrictive and therefore disabling mental health understanding and recovery.

***P11:** careful not to undermine his religious beliefs even though I don't share them but equally the fact that they were negative and holding him back there was something that needed to be addressed about that*

***P5:** this one woman I worked with who had this very strong belief about Jinn{...}that felt quite limiting, because she had quite a strong belief system about something completely different*

Participants appear to identify some beliefs as problematic or fixed and felt unsure what to do about them and whether to intervene. Implied in this may be an assumption that a religious or cultural belief may be limiting service users' recovery and needed to change.



*P3: they have their own explanations linked to their religious beliefs and its sort of impossible to change*

*P10: reflect that you've acknowledged what they're saying and then come from it from a different perspective...to see if they get some sort of conclusion from it I mean sometimes that doesn't work{...}you just kind of have to let it go as long as it's not affecting you know themselves or other people*

It may be considered that these professionals shared a sense of uncertainty about how to respond to cultural or religious beliefs, perceiving these as limiting within the individualised, western approaches they were undertaking with service users. However, there was also a sense that these beliefs would be tolerated so far as they did not pose risk to anybody.

Professional narratives were also seen to dominate in the understanding of culturally different expressions of distress, such as with ideas of 'somatisation' or 'culturally-specific conditions'.

*P1: particularly Muslim women would kind of present with physical ailments I thought this was probably kind of an underlying kind of depression or loneliness{...} there was this kind of idea that these women might kind of re-presents to kind of services again and again kind of with the same pains*

*P4: we have like culturally specific psychiatric conditions which only happens in the culture and you definitely have to think about why this person has sudden beliefs or why the symptoms present this way*

Western ideas on how distress should be conceptualised or manifests appear to be implicitly assumed to be universal, meaning that when different manifestations of distress occur they become subject to queries about credibility or pathology and reframed into western constructs (e.g. 'somatisation', 'culturally specific conditions').

### **3.3 Theme 3: Constructions of the Professional Role and Implications for Mental Health Practice**

This theme included participants' constructions of professional roles and practices. The epistemological positioning of professional's approaches appeared to affect their application of mental health models; with universalism leading to adherence to standard practice and considerations of cultural relativity leading to critical approaches or adapted practice.

### 3.3.1 Sub-Theme 1: Construction of the Professional Role as Being 'Objective'

Participant often referred to ideas of objectivity and neutrality in how they approached their work with service users.

*P10: I try not to think too much about if that's in relation to me like what they are experiencing cos I still try...like try and be objective*

*P5: I guess you just try and bracket your own beliefs and examine them in the light of what people tell you because I guess you are just there as a sounding board*

It may be considered that these ideas reflect a professional discourse for the need to remain neutral and objective, thus suggesting that professionals did not bring in their own experiences, ideas or cultures into their practice.

*P1: I try and kind of explore things as much as possible with patients without trying to bring my own experiences*

*P10: I've got colleagues who are from Nigeria but then I just I don't know about their culture and like their sort of customs in relation to where they're from*

Neutrality appears to relate to culture more widely, both western and non-western, and there is a sense that this is not brought to work or talked about. One participant discussed examples of the perceived dangers of introducing cultural or religious values into care.

*P2: I mean I've had nurses who have gone to speak to patients, Christian Nurses who go and speak to patients and talk to them about God on the ward and I've had to take them to one side*

*P2: I had somebody a nurse who dismissed a patient...she'd had FGM, female genital mutilation{...}this is something that's happened, she's brought it up, it seems like it has bothered her, this is a trauma, it's illegal we need to do something about that but one of the nurses laughed and said well it's just part of the culture you just don't understand*

These perceived examples of 'getting it wrong' highlight the range of cultural experiences or ideas that may be held by professionals and how these may interact with ideas about professional conduct in the UK. Implicit Eurocentric and secular norms may be seen as 'common sense' ideas about how professionals should think and practice.

A participant from a non-western culture spoke about their encounter of their own culture in their professional role.

*P10: I identify myself as (South Asian ethnicity) and even like my colleagues just didn't really know about the culture{...}I'm gonna be honest with you um my first experience of working with a (South Asian ethnicity) person...I wasn't comfortable like I felt like it reflected like my culture{...}um I was almost embarrassed to work with them*

This participant spoke about embarrassment and discomfort in encountering their culture at work, expressing concern about how this might reflect on that part of their own identity. The lack of presence of their culture in their workplace was also noted. This may suggest a splitting off of 'culture' in professionals where their culture is perceived to deviate from a 'neutral' or 'professional' identity.

### 3.3.2. Sub-Theme 2: Construction of Religious Belief as Separable from Other Issues with Little or Minimal Relevance

This theme notes participants' accounts of separating religious ideas from their understanding of 'mental health'. Religion was often seen as peripheral and therefore not thoroughly inquired about, emphasised or integrated into frameworks of understanding service user's mental health. This was noted to be in direct contrast with Muslim and Islamic conceptualisations of mental health.

*P6: generally speaking erm most of the cases it would already be on the demographics and I may not ask that specific question if that was the case.*

*P4: it usually just comes up as I'm taking the history usually they would kind of be quite keen to talk about it even without me prompting too much*

Participants showed a lack of emphasis in enquiring about religious beliefs when working with service users, often relying on standardised methods of collecting demographic information or otherwise waiting for this to 'come up'. This may highlight the de-emphasising or minimising of the importance of religious belief beliefs more widely.

*P2: the only thing that was there before and would make a big difference to people, not just Muslim faith everybody really, is more nurses on the ward being able to spend more time with patients...being interested in them*

*P1: so people that follow Islam it's kind of difficult for me to kind of explore that idea in more detail{...} it tends to be that I kind of see patients for like one off reviews rather than follow through for a long period of time.*

The lack of inclusion of religion may also be related to the lack of time in which professionals have to consider this, however this itself may also be considered with regards to what ideas are prioritised in mental health frameworks and how this affects how interventions are delivered.

It was noted that participants appeared to consider religio-cultural beliefs and practices around distress as separate from the 'mental health' problem.

*P4: most of the patients they would be quite aware that a mental health issues is a separate problem{...}in terms of their religious beliefs or spirituality*

*P11: well some of them have talked about Jinns and that kind of thing... but there was also a sense of something separate too*

Islamic religio-cultural beliefs may therefore be considered as marginalised with regards to the value afforded to them in explaining distress or informing interventions, with western 'mental health' frameworks prioritised and held as an unquestioned reality.

*P8: I just think is kind of personal and not necessarily to do with me you know...some things that they are bit more personal and deep if it's if it's relevant I get to know them otherwise yeah otherwise I don't really ask*

*P9: how much time to devote to talking about their religion and faith in relation to the other things you're meant to be doing{...}and that sort of a bit like wariness of asking questions that might be offensive or would be intrusive*

This separation appeared to be connected to questions about the relevance or importance of addressing these religious beliefs within their adopted mental health frameworks. However, wariness and fears of being intrusive or offensive were also mentioned which may suggest a sensitivity around asking about religion in general or Islam in particular.

Participants who perceived religion as important themselves, or to service users, appeared more open to involving consideration of religion and culture into their work.

*P5: it depends I guess how important it is to them{...}it being part of their belief system about the mental illness*

*P11: maybe other people wouldn't necessarily pick up on about faith or their religion...I think it is important and you know it's part of their internal world how they work how they view life and their place in that*

However, this highlights the power that professionals hold in the determination of whether these considerations are included or integrated into mental health interventions and how this is done, irrespective of the significance this may hold for service users.

*P8: I was more thinking of a holistic approach...how to increase their functionality or how to connect with certain sort of activities*

*P10: there was like different times where he would eat as well so we had to make sure that there was like a specific meal for him{...}making sure that things are person centred and individualised*

Where religion was integrated into mental health provision there appeared to be an overreliance on including practical adaptations to facilitate the practice of the religion, as opposed to integrating religio-cultural understandings of distress in framing interventions.

However, the Muslim participant highlighted the integral role that religion played in their interventions when working with Muslim service users.

*P7: To make any kind of assessment or intervention meaningful I guess its felt, for me, that I've needed to include it{...}a lot of them have been (South Asian ethnicity) and have Muslim names but not all of them identify as Muslim{ ...}that's probably less to do with being Muslim and more about culture, but sometimes the two are a bit intertwined*

The nuanced understanding and familiarity with the religio-cultural aspects of Islamic identity was also recognised by this professional, informing their approach to practice.

*P7: that's the other experience I've had which is a bit different to being a psychologist in some ways, although it's not that different, but through kind of including people's cultural practices including people's kind of religious practices and responding to that*

However, this led to them questioning whether that was part of their professional role.

### 3.3.3 Sub-theme 3: Acknowledgement of the Limitations of 'Western' Models

The theme captures the critical ideas expressed by some professionals interviewed regarding the limitations of the models and approaches used in mental health practice when applied to non-western cultures. However, there were limitations in how this could be understood as producing inequalities and talking about the presence of discrimination in services appeared to be challenging.

*P1: most of the models that we apply are probably ones that have been kind of developed in the West and probably don't take kind of a lot of those cultural factors into account {...} written what kind of 20-30 years ago*

*P5: how people perceive mental health there and how very often it's linked to spirits and the spirit world and spiritual understandings{...} if you just tell them about CBT or the biopsychosocial model... they don't, it's not the same as if you've got a broken arm*

Some professionals showed critical consideration of the appropriateness in applying Western literature and theories about mental health to culture and context where understanding about these experiences diverged from western experience. The datedness of many of the theories were also noted, in reference to the changes seen in multiculturalism in the West since the development of these theories. However, consideration or awareness of different approaches or ideas about how to work around this appeared absent.

Reference were made to the lack of consideration in the design of services in responding to the religious and cultural needs of Muslims.

*P9: things like around Ramadan...I know some services if you miss a certain number of appointments...there wouldn't be that flexibility in appointments*

*P8: they say 'it's Ramadan so maybe probably for me I'll want to meet you after that' and then I was like OK yes the whole month so I said that they not engaging they're not interested...and then you just know realise you know that it's not about that*

A lack of awareness or consideration of the cultural and religious needs of Muslims was noted as leading to misunderstandings about Muslim service users' interest or willingness to engage with services, potentially leading to them not receiving further support.

The prevalence of 'white' identity in mental health professionals was pointed to by some participants as a factor in how services responded to Muslim services users and diverse cultural or religious needs.

*P9: services which were pretty much all white middle-class people working there using... the western understanding of mental health*

*P5: white and middle class...there is overrepresentation in clinical psychology*

*P7: I think they are seen as very separate which is worrying because if you accept that they are separate then you are accepting that the psychology workforce doesn't reflect the people that we work with and we are not doing anything about that*

Through this recognition it may be considered that participants showed some reflexivity about the dynamics which may play out between mental health professionals and service users, with regards to issues of difference, power and marginalisation.

Other participants talked about trends they had seen in the exclusion of Muslim patients in certain areas of mental health care provision.

*P11: in the (specialist mental health team name) a tiny proportion of the patients we see are from that background{...}is that people's prejudices...people aren't being put through to the same sort of care*

*P4: so personally I haven't come across an obvious case where someone has been treated differently just because of the Islamic identity erm but at the same time I also see that a lot of these patients don't present to certain types of services{...}i've never seen any patient in fact from the Islamic background being referred to tertiary care*

Some references were made to the role of professionals' judgements in the disparities in service access, however this appeared very tentative and there seemed to be some hesitation in labelling these disparities as relating to structural inequalities or discrimination.

*P11: I do think it was racism...I mean I think... well that's a bit of a statement to say isn't it{...} the (name of cultural specialists service)...I think what they provide for the team wasn't seen and valued in the same way... partly I think that was weirdly because of administrative{...}I think it was a real mixture of things*

Where racism was considered by this participant, in relation to the defunding of culture specialist's service, they appeared hesitant in labelling it as such and other explanations were instead provided. The difficulty of talking about issues racism or structural inequalities toward Muslims within services is marked when compared to the awareness participants showed about the existence of this context for Muslims in wider western society.



*P4: I don't think its specific to Islam I also see in other religious groups and other cultural groups as well but definitely nowadays London this group report to me they are the most frequently reporting feeling quite paranoid when outside, being attacked either verbally or physically....so that needs to be in our awareness really for all the religious and cultural groups.*

Despite acknowledging disproportionate reporting of discrimination by Muslim service users, the importance of being aware of anti-Muslim discrimination was considered alongside discrimination amongst other religious and cultural groups.

The binary of oppressor-oppressed was a theme discussed by participants who spoke of their discomfort talking about power imbalances and cultural differences.

*P11: I think that it can feel very um that you are either in it or your out you know what I mean you're either the oppressor or your part of the...*

*P1: race and kind of racial prejudice is kind of a big topic in general...I would think oh! maybe I would have said that or like not realised that that would be kind of offensive*

*P9: I think too there is something now isn't there in society about like causing offence and saying the wrong thing and people being called out and cancelled*

Awareness of one's own privilege and reductive binaries of oppressor/oppressed may be here seen as contributing to defensiveness or avoidance in engaging with the topic of Islam, in fear of perpetrating or enacting oppression and being 'cancelled'.

*P7: we are probably having those conversations more because I'm asking those questions.*

However, the Muslim professional interviewed was the only participant who spoke about raising these dialogues.

#### 3.3.4 Sub-Theme 4: Accounts of Attempts to Develop More Culturally Appropriate Professional Practices

This subtheme highlights the attempts made by a number of participants to adapt their practice to include more culturally appropriate modes of care. This often began with recognition of practitioners own limitations in understanding a cultural or religious difference and then involved the utilisation of alternative models or local support resources in order to enhance their interventions and gain better understanding of how to work from within service users own frameworks of support and understanding.

*P5: I'm conscious that there is a lot of sort of bias and prejudice and racism involved in their sort of public experience at the moment and I suppose in some ways maybe that part of positioning myself and it's almost part of trying to create a sort of safe space and at the same time of course I know that I don't really understand what it's like*

*P1: I've never been I've never been psychotic and also I'm not religious so I think it's kind of probably quite difficult for me to understand that and how it might come about err and so I guess the only way that I can try to understand it is just by kind of observing and listening to kind of what they say*

These participants showed an understanding of the importance of examining their own experiences and influences and how this might affect their interpretation of a different experience, suggesting that professionals may often use their own experiences and understandings as a reference in their clinical work.

For some professionals a gap in their understanding led to them seeking different ways of working and considering the need for them to make adaptation rather than the service user.

*P9: I had to sort of think a bit more broader about his support network then I might do typically I guess in terms of thinking about like the nuclear family*

*P11: systemic therapies quite helpful {...} I did a lot of work, co-work with the (cultural advisors team){..}with the interpreters*

*P4: advice from the chaplain erm that was quite helpful {...} they had a GP who was also a Muslim...was able to kind of put it across to her in a really kind of really nice and sensitive*

*way{...}incorporate some of the teachings from the Quran and religious beliefs into how you understand mental illness*

Participants who adapted their work in this way appeared to open up their interventions to include support from other professionals who had religious or cultural insights which they could use to develop their communication with service users and develop their own understanding of religious or spiritual factors. Utilising narrative or systemic therapeutic approaches also seemed to be part of this broader decentralising of the professionals' knowledge or interventions in considerations of how to provide support.

Some professionals also spoke about integrating themselves into service user's contexts and environments to facilitate this adaptive approach to providing support.

***P5:** we had a very good conversation with the imam and I felt afterwards that the brother certainly opened up to us a lot more{...} because it felt like we had shown willingness to understand where they were coming from*

***P7:** respecting each others' faiths and being a community, being part of a community even if you're a service*

***P11:** very much catered to respond to the needs of the community in that community...it had a significant influence over the way we worked I often felt more that my specialism wasn't so much (diagnosis) but it was working with Muslim (South Asian Ethnicity) families with (diagnosis)*

Participants spoke about how their willingness to enter into service user's frameworks for support and show respect and engagement with cultural or religious practices and beliefs had fostered improved relationships and engagement with Muslim service users. The divergence of this approach from standard care provision may also be noted by participants descriptions of this as exceptions from standard care.

The exceptionality of having a space to integrate and include religious or cultural identity into mental health practice was mirrored by the Muslim participant.

*P7: once I had that space I was like oh this feels so much better and really important and I hadn't realised that I had not had that space before and that I hadn't been asked about these things {...}led me to think about the people we work with and if I'm noticing that we don't have that space then what about the people we work with, do they have that space?*

The sense of having a right to a space in mental health which was considerate of cultural and religious identity appeared novel and exceptional to this participant, in the professional space and they reflect the impact this may have on the appreciation of these factors in spaces provided to services users. The power of professionals in determining how mental health is conceptualised and responded to is noted here and participants spoke about encountering resistance when challenging standard care practices.

*P7: I've felt more able to ask the questions...I have met a lot of resistance*

*P5: he said, well lets go and I'd like to introduce you to the imam{...}. and the OT was saying "woooooahh woah woah we shouldn't really be going" ... "I'm not sure we should be going to the mosque" and I said to her you know well we would do this if we were going to a church...we send these people to churches all the time without asking or thinking about it*

This resistance may be seen as uncertainty towards incorporating religion into mental health practice more generally, but there is also an indication that this may occur especially in relation to Islam, which may reflect something wider about the way that ideas of integrating Islam specifically into the 'West' may be met with uncertainty.

## **4. DISCUSSION**

### **4.1 Overview**

This study's research questions were:

1. What discourses do mental health professionals draw on when encountering Islam, Muslims or racialised 'Muslims'.

2. Has this interacted with their clinical judgements, decisions and practice?
3. What influence do the epistemological position, training and diversity of professions have on practitioners?

The three main themes that emerged from the data will now be discussed considering existing literature.

## **4.2 Linking Findings to Research Questions and Literature**

### **4.2.1 Knowledge About Islam- Sources and Extent of Knowledge**

The centrality of White, ‘Western’, Christian or Atheist culture and experience amongst mental health professional was highlighted in this research. It was noted that Islam was often considered in relation to participant’s own cultural frames (O'Connor & Vandenberg, 2005; Colgan, 2015). However, professionals who spoke about having limited contact with cultural or religious diversity or Islam appeared to make judgements about Islam as being in contrast with their own cultural values. These judgements appeared to be rooted in Orientalist assumptions of Islam as being opposite to ‘liberal, progressive Western society’ (Said, 1978; Allen, 2010) and may then be an available frame of reference for people and professionals to draw upon in the absence of contact with Muslims or knowledge about Islam.

Where participants reported more exposure to diversity or held a religious or culturally marginalised or misunderstood identity themselves, they appeared to have an awareness of the propensity for misconceptions and marginalisation toward Muslims (West, 2019). Having contact with Islam through close personal experiences appeared to similarly facilitate a ‘demystifying’ of Islam, which made Islam or Muslims appear be perceived more positively, reducing the ‘us and them’ discourses. Their accounts implied that prior to these contacts, hostile and othering narratives about Islam were available in professionals’ minds, indicative of their prevalence in Western social discourse (Ahmed & Matthes, 2017). These findings highlight the countervailing effect that cultural or religious diversity in professions (Kline, 2014; West, Dawson & Kaur, 2015) and contact based approaches to facilitating intercultural understanding (Harris & Hussein, 2018) may have in providing more inclusive care and resisting negative social discourses about Islam.

Lack of training and education about cultural and religious care was noted by participants in this study, as it has been elsewhere (Crossley & Salter, 2005; McSherry & Jamieson, 2013); especially specificity in learning about specific religions including Islam. This may reflect a failure of professional bodies in ensuring that sufficient spiritual and cultural teaching is provided in training programs, despite this being recommended in national mental health policy (Department of Health, 2009;2011). Generalised and superficial discussions of ‘culture’ and ‘diversity’ were instead noted by mental health professionals as unhelpful, supporting criticisms made of ‘cultural competence’ trainings (Bhui et al., 2007; Truong, Paradies & Priest, 2014). Some professionals’ spoke about similarly adopting a non-specific ‘holistic’ or ‘individualised’ approach with Muslim service users as they would with any service user. However, this may be understood as adopting a ‘religious-blind’ approach, as noted by the Muslim professional, who considered this an erasure of service users’ identities and needs, under the guise of ‘equality’. Indeed, undertaking such an approach may be reflective of a more individualised, liberal humanistic position as noted in *section 1.2.6.1* (Maslow, 1970; Bilgrave & Deluty, 2002; Norton & Tan, 2019) whereby religion is considered through individualised terms. Therefore, it may be considered that religious and cultural needs may continue to be subject to professional’s own values and ideas (Crossley & Salter, 2005; El-Nimr et al., 2006) if they are not explicitly prioritised and considered in mental health trainings or workplace environments.

This may help account for the participants’ persistent lack of knowledge about Islam despite reporting extensive experience of working with Muslim service users. As little standard had been provided to participants on what they needed to know or consider, professionals spoke about relying on Muslim service users in raising their cultural or religious needs. However, questions might be raised about how much these service users may feel willing or able to do this given the secularity of mental health models, their relative positions of power compared with professionals, and the stereotyping and securitising of Islam at this present time (Rethink, 2007; Chew-Graham et al., 2002; Weatherhead & Daiches, 2010; Muir, 2016). It may also be questioned whether professionals can respond appropriately to these contributions without sufficient training. Therefore, the ethicality of relying on service users, who are often experiencing distress at the point of these contacts, may be important to consider.

In line with the wider literature (Sheridan, 2006), many participants reported that Muslim service users commonly disclosed experiences of anti-Muslim discrimination, increasingly so since 9/11 and in relation to incidents of terrorism. Anti-Muslim discrimination also affected the Muslim professional in professional spaces (Choudhry, 2016). Whilst participants made general reference to the current social context of Islam in the West, they did not refer to the wider effects of this on Muslim experience and showed some hesitation in how much they should discuss these issues in their work with service users. This may be reflective of a wider lack of integration of social, material and political contexts in mental health frameworks and their subsequent insufficiency in producing interventions which challenge discrimination and inequality (Johnstone & Boyle, 2018). However, this may be further exacerbated by the naturalisation and legitimisation of anti-Muslim sentiment in the West, whereby Muslim experiences of discrimination may be normalised or minimised (Conway, 1997).

These contexts may then explain why participants viewed Muslim service users' reports of discrimination as peripheral, focussing instead on the 'symptoms' or psychopathology related to it, rather than considering the "understandable, and, indeed, adaptive" vigilance experienced by targeted social groups (Shevlin et al., 2015, p. 213). Muslim service users have highlighted concerns that their experiences would be interpreted as such in previous literature (Byrne, Mustafa, & Miah, 2017).

#### 4.2.2 Assumptions and Their Consequences

Assumptions of Islam as being linked to 'traditionality' (high religiosity, adherence to non-Western culture) were common in participants accounts. This 'traditional Islam' was associated with 'backwardness' and a lack of progressivity when compared with typically Western associated values or culture. Islam was conflated with ideas of restrictiveness, especially with regards to Muslim women (Bouferrouk, 2019; Hasan & Mohammed, 2019). Traditionality was seen to link with heightened suspicion and perceived levels of risk from some participants (Ragazzi, 2016a, 2016b; Ahmed & Matthes, 2017). These assumptions can be seen as rooted in essentialised Orientalist and Islamophobic ideas about Islam (Said, 1978; Conway, 1997; Izadi & Saghaye-Biria, 2007) and were linked to professionals' feeling of distance, mistrust or unrelatability towards Muslim service users.

These essentialised and inferiorising discourses about Islam have been connected to the 'dehumanising' of Muslims (Said, 1978; Kteily et al., 2015; Samari, 2016). Therefore it may

be important to consider to what extent professionals' sense of 'unrelatability' or distance to Islam may be associated with dehumanising elements of 'othering', as this has been linked to reduced professionals' levels of empathy towards service users (Lebowitz & Ahn, 2014); which in turn can have a negative effect on clinical outcomes (Elliot et al., 2011).

However, some participants also showed raised suspicion or scrutiny towards Islamic associated religious or cultural practices, through a heightened focus on risk in relation to these (e.g. fasting), as noted by Laird, Marrais and Barnes (2007). Racialised violent practices, such as forced marriages and 'honour-based violence' also appeared to be related to Islamic religion or 'traditionality'. The role of racialised, orientalist frameworks on such practices have been noted widely in literature (Razack, 2004; Imkaan & Rights of Women, 2016a; 2016b; Patton, 2018) and the problems of these discourses in narrowing the frameworks available to women seeking to escape violence have been noted. These findings point to the role of how cultural unfamiliarity may interact with primed social narratives, leading professionals to encounter Muslim service users, families or communities in a way which is hesitant, mistrusting and securitising. This may contribute to what Byrne, Mustafa and Miah (2017) referred to as a new 'circles of fear' with Muslims and may help to understand the role that professionals and services play in distancing Muslim communities from mental health services, through a sense of mistrust and the re-enacting of the securitisation of Muslims.

Interestingly, 'Westernised' Muslims, who were born in the UK or had been exposed to British culture or education were discussed differently by participants. Their perceived 'ability' to 'hold two perspectives', including a bio-psycho-social 'mental health' framework, was considered advantageous and these 'accultured Muslims' were storied as more open and more amenable to mental health professionals; and were, as such, met with more ease by participants. This may show the role of familiarity in making professionals feel more at ease in delivering their interventions, however it may also exacerbate colonial discourses of 'accultured' Muslims who are 'educated in' and adhere to 'Western' concepts as being more favourable and amenable than 'traditional' Muslims who hold other cultural or religious beliefs about mental health (Grosfoguel & Mielants, 2006; Pilkington et al., 2012, Laird, Marrais & Barnes, 2007).

Where Muslim service users did maintain ideas about distress and intervention which were religiously or culturally 'non-Western' or unfitting with the 'absent standard', this was seen



by participants as limiting their engagement with professionals. This included the role of family or community involvement in supporting distress being seen as restricting and potentially pathological ‘over-involvement or interfering’ (Naeem, Phiri, Rathod & Kingdon, 2010). Belief in religio-cultural ideas such as *Jinn*, ‘fate’ or the will of God were similarly, at times, described as potentially problematic or limiting mental health recovery or the utility of interventions (Mir & Sheikh, 2010; Hassan et al., 2020). This elicited, in some professionals, uncertainty about what to do with such beliefs and consideration that perhaps these needed to be challenged or changed, as noted by previous research (Jackson & Coyle, 2009). Other times variation in how distress presented or was understood by Muslim service users were considered as indicative of them being ‘less psychological’; reinforced by narratives such as ‘psychological mindedness’ and ‘somatisation’ (Hussain & Cochrane, 2009) and leading to their exclusion from psychological services.

Together these findings show that ‘religious or cultural difference’ in expressing or understanding distress were viewed as separable and inferior to prioritised, ‘Western’ frameworks (the ‘absent standard’). This amounted to epistemic injustice, as cultural and religious frameworks, which could not be understood through the lens of Western mental health frameworks, were considered as lacking credibility in providing an explanatory framework for distress or in informing ‘appropriate’ mental health treatments (Fricker, 2007). This also led to the exclusion of service users' own frameworks of their distress and may have restricted their access, through professionals and mainstream services, to culturally or religiously appropriate support; and in some cases to standard care options, such as psychological treatments or specialist care services.

These insights may be important for understanding the disparities in access and outcomes seen in Muslim service users in mental health care. It may also help us to understand why the provision of inflexible or culturally inappropriate care may persist, despite reported poor outcomes and national policy highlighting this as a priority. Islam’s position as a minority religion which lacks a strong cultural frame of reference in the UK (e.g. how to manage *Jinn* possession) may be further exacerbated by the negative and inferiorising social discourses that exist about the religion in the West; which may lead to the discrediting or pathologising of such beliefs, rather than a relativist understanding of them as different. This was noted in O'Connor and Vandenberg’s studies as occurring towards the Nation of Islam, similarly, based on the social positioning of that religion in their research context (2005;2010).

#### 4.2.3 Constructions of the Professional Role and Implications for Mental Health Practice

Participants' accounts regularly referred to a need to remain 'objective' in their approach to their clinical work. It may be considered that implicit in this is the belief that models and approaches used by professionals are themselves cultureless, objective and universal; and that 'professionalism' requires that professionals similarly reflect this (Sakomota, 2007). Patel (2003) writes of the depoliticisation that occurs when mental health professions are positioned in this way, leading to a lack of examination of the assumptions and values which they carry and are embedded into ideas of 'professionalism'. Contrary to being unpolitical, this objectivity may be understood as professionals' embodiment of the 'absent standard', implicit in mental health approaches (Sampson, 1993; Gaines, 1995), which leads to the continued othering of 'culture' to non-Western cultures and may be seen as a re-enactment of colonial hegemonic ideas of Western superiority (Sakamota, 2007).

The inclusion of non-secular or non-Western subjectivities in participants' accounts, such as the example of a nurse talking to service users about God or expressing a different subjective position on FGM (see section 3.3.1), appeared to lead to the questioning of professional integrity; something which has been echoed in wider literature (Kendall-Raynor, 2009; McSherry and Jamieson, 2013; Choudhry, 2016; Ragaven, 2018; Poole, Cook & Higgo, 2019). Such finding may be seen as supportive of the idea that mental health professionals may feel they need to take on a 'white identity' to be seen as professional (Yan, 2005). This splitting of culture and religion from 'mental health' was echoed in participants' constructs of these as separable and of little relevance to each other. This occurred despite this being in direct contrast to how some Muslim service users appeared to have understood their experiences of distress. The adoption of Western paradigms as unquestioned, objective and universal meant that religious or cultural variance were framed as a subsystem of beliefs, rather than as epistemologies themselves which hold foundational frameworks from which experiences can be explained (Patel & Shikongo, 2006). This may further support the idea of epistemic injustice and racism faced by cultural or religious minorities in mental health.

As noted in previous research, psychiatrists predominantly used disease processes and diagnoses as a framework from which to understand cultural variations in mental health presentations (Colgan (2015). However, 'psychologising' frameworks were used by all professions, especially clinical psychologists, to understand religious or cultural frameworks

as a ‘way of making sense’ of experience or as serving ‘psychological functions’ (Jackson & Coyle, 2009). Mental Health Nurses reported using a mirage of bio-psycho-social frameworks to inform a “holistic” approach to mental health care. Whilst noting the role of spiritual and cultural care as part of nursing practice (Eeles, Lowe & Wellman, 2003), this study found that religion or culture was considered mainly with regards to practical adaptations to support the practicing of faith, and spiritual or cultural understandings were subject to interpretation through a bio-psycho-social lens. This may be considered with regards to the relative lack of power that nursing frameworks hold in multidisciplinary teams, and the noted institutional and discursive dominance of mental health nursing education by biomedical psychiatry (Adam, 2017). These findings may also further highlight the dominance of Western ‘mental health’ frameworks in encountering religious or cultural ‘difference’, across all professions.

The level of how much religion and culture was raised by professionals appeared dependent on professionals’ perceptions of how important this was. This echoes research showing that professionals may use their own values in determining whether or not to discuss religion (Crossley & Salter, 2005; El-Nimr et al., 2006). The power held by professionals in determining the frameworks used to understand and treat distress may then need to be addressed due to its conflict with mental health policy and impact on equity of care for religious service users.

When encountering Islam or Muslims in their clinical practice, participants spoke about uncertainty in asking about Islam, linked to discomfort about talking about ‘personal’ things or fears of causing offense. This may be linked to a wider uncertainty in professionals on whether, or how to talk about religion (Crossley & Salter, 2005; McSherry & Jamieson, 2013). However, narratives about Islam as ‘closed’, ‘dangerous’ and ‘very different’ may be used to further understand this hesitation, as well as the salient discourse of Islamophobia in the West at present (Conway 1997; Mistry et al., 2009). It has been suggested that Islam in the West has become a phobic object, which is viewed through the lens of fear (Homayounpour, 2019). Jadhav and Younis (2018) highlighted the censorship and hesitation experienced by professionals when encountering Islam, related to attendance to PREVENT training, whereby they felt avoidant of asking more details about Muslim service users in case they heard something which may raise concern. This may be seen again as having an

impact on developing therapeutic relationships with Muslim service users and ensuring they get access to appropriate care.

Some participants highlighted the limitations of the Eurocentricity of mental health approaches and the overrepresentation of “whiteness” within mental health professions (Wood & Patel, 2017) in providing appropriate care to Muslim service users. Implicit in these appeared to be a sense of understanding the way that structural inequalities may manifest in these gaps between services and service users, however participant appeared hesitant to name examples of structural inequalities towards Muslims they had seen in services as discrimination. Professionals often generalised the difficulties faced by Muslim service users to broader contexts of social inequalities as being experienced by many social groups. This generalising may reflect a wider obscuring of the impact of marginalisation that privileged groups engage in, in order to avoid building an understanding of a specific discrimination and their role within it (Grillo & Wildman, 1991). Some professionals’ spoke about the discomfort it raised for them to occupy an ‘oppressor’ position; therefore, this may be avoided by broadening the oppressed position to all difference, including ones that they may occupy (e.g. social class, gender). However, this ‘appropriation of pain’ diminishes the unique difficulties faced by Muslims in the UK and professionals’ own contribution to this. The difficulty in engaging in dialogues about difference and power, or in naming Anti-Muslim discrimination was highlighted by participants, as was the lack of spaces for consideration of these issues within professional spaces (Wood & Patel, 2017). However, considerations of ‘white privilege’ and ‘white fragility’, developed from critical race theory (Delgado & Stefancic, 1993; DiAngelo, 2011), may also be used to understand their engagement with these issues. The ‘challenging’ nature of such dialogues and the privilege afforded by “whiteness” often mean that the responsibility, or burden, of raising these issues may fall to those who are affected by them.

It was noted that the Muslim professional interviewed, expressed active steps they had taken to engage in conversations about difference and inequalities, despite inequalities being noticed by many more. They also spoke of their experiences of the exclusion, and sometimes discrimination of their religious and cultural beliefs in mental health spaces. They considered the way this may mirror service users’ experiences, sharing the experience ‘being Muslim in the UK’ (Choudhry, 2016).

Professionals who had critically reflected on their personal and professional limitations in meeting the needs of Muslim patients, reprioritised their approaches to mental health to fit the frameworks of service users and adopted practices rooted in different epistemologies to standard mental health practice. Some examples included using approaches stemming from epistemologically relativist positions, such as narrative therapy or social constructionist systemic family therapy; as well as the utilisation of chaplaincy services, interpreters and community advisors, in order to incorporate and integrate differing understanding of mental distress. Literature has shown positive reception of these approaches with Muslim patient groups (Byrne, Mustafa, & Miah, 2017; Maynard, 2008; Cardo, 2014). Some participants also discussed integrating with local communities or service users support systems, such as attending mosques, in order to facilitate mutual respect between mainstream services and Muslim service users and communities. However, participants described resistance, discomfort and hesitation from colleagues (Choudhry, 2016; Byrne, Mustafa, & Miah, 2017). These may again be seen as the interaction between uncertainty, unfamiliarity and the availability of negative social narratives about Islam which highlight it as incompatible with the West and as such raises resistance towards the integrating of Islamic practices into Western society (Nagel & Staeheli, 2009; Zempi, 2019).

### **4.3 Critical Evaluation**

In evaluating this research, Yardley's (2000; 2008) procedures for enhancing and demonstrating the quality of qualitative research were applied.

#### **4.3.1 Sensitivity to Context**

As noted in the ethical considerations of the study, the unique context of Islam in the West, specifically in the UK, at this time in history was considered throughout the process of this research. The idea of Islam as a sensitive topic in the West and the impact this may have on professionals' willingness to talk openly about Islam was noted in the literature review and this was considered in the analysis of the latent content in the data. My dual position as both Middle Eastern and 'colleague', in the sense of similarly belonging to a professional group, was also considered in terms of how this may have influenced the interview processes and how this may have interacted with my interpretation and analysis of the data. For this reason, the data was heavily used to provide empirical evidence of the interpretations made (Yardley, 2008).

#### 4.3.2 Commitment and Rigour

The process of data analysis included hand transcription of all interview data by the researcher and a repeated process of familiarisation with the transcripts in order to develop and continually refine codes from which themes would be identified. This was done to ensure that the meanings and interpretations were derived from the data, as much as possible, before being associated with theories available from the literature search. This process was supported and reviewed within research supervision in order to provide a different perspective on the coherence and strength of the identified themes and to ensure adherence to the process of thematic analysis as outlined by Braun and Clarke (2006). Candidate themes were revisited and adjusted in this process and this process can be seen in Appendix N.

#### 4.3.3 Transparency and Coherence

Transparency of the research was attempted through providing information about the epistemological position taken in the research process and by providing a detailed outline of the research process and reflective accounts in the Methods chapter. An excerpt into the way the data was coded and how these codes were formed into themes is provided in Appendix L & O to further enhance the transparency of the research process.

Coherence was ensured by using a critical realist approach to thematic analysis, which matched my epistemological position in the research and allowed for participants' constructions of Islam to be considered widely, as informed by their own relative positions and experiences, before linking this to the existing literature and theories. The interpretation of the data in the analysis was closely linked to the data itself to further ensure this. A coherent constructed story of the research, linking the literature review to the data was then provided in this Discussion chapter.

#### 4.3.4 Impact and Importance

This study is timely given the dearth of literature considering the impact that the racialisation and politicisation of Islam has had on access to mental health care (Laird et al., 2007). It's novelty in seeking to provide rich data on how mental health professions develop their clinical judgements and how this interacts with their clinical practice, holds relevance beyond the construction of Islam. The research's bravery rests in its seeking to open, and make visible, dialogues about Islam in the professional sphere, where public discourses about Islam remain insidious and contentious. There has been disproportionate focus on barriers to

accessing service that lie within service user groups therefore this study has aimed to offer something introspective to professions and professionals in what their role may be in alleviating disparities in care.

#### 4.3.5 Other Methodological Considerations

The majority of professionals interviewed were based in London, which holds much larger Muslim populations and multicultural diversity than other parts of the UK. This increased exposure to religious and cultural diversity was noted in many professionals as a contributor to the way they constructed Islam. References were made by some participants about a striking difference they had noted working in different parts of the UK, notably reference to ‘the north’ and ‘London’. Such findings highlight the variance which may be found across the UK in terms of how Islam may be constructed and how this may affect mental health practice and care.

Participants willingness to undertake his project should also be considered in relation to what this may suggest about their openness to Islam and talking about a topic which has been in social consciousness and politicised. Such factors should also be considered in relation to how representative this study’s findings may be to people who are less willing to consider such issues and who are less open to talking about politicised matters or engage in research about how they consider and work with Islam, as such persons may express many important themes which could not be identified in this research. Attempts to manage overinclusion of participants who had an active interest in Islam or who had a lot of experience thinking about or working with the religion, was managed by asking these questions in the recruitment stage (Appendix G).

Lastly, the use of non-random sampling in this study, recruiting participants of who are affiliated and therefore may share a likeness, limits the generalisability of the study’s findings.

#### **4.4 Reflexive Review**

Through the process of advertising and recruiting the project I became aware of how often therapists of Islamic backgrounds made contact showing interest in the study. It made me consider the significance that such research may hold for Muslim professionals, as a mirrored

experience of service users, who may not feel well served by mental health frameworks in the UK. I was aware of the lack of much (research, teaching, colleagues) I had encountered in my own training in helping me think about the experiences of Muslims in the UK and in mental health care. At the same time Islam was extremely apparent in ‘the service user’, in vignettes used in teaching or case presentations in mental health services; often involving comments which I perceived as stereotypical. I noted a gap between how I read the research data and how for example my white, non-Muslim supervisor, or a potential white, non-Muslim examiner might. I equally noted a sense of hesitation and worry about applying certain interpretations to participants’ talk, with fear of them taking offense or taking it in an accusatory or persecutory way.

This felt important to notice, with regards to the force that dominant identities and discourses may enact on the process of unearthing implicit or subjugated narratives in this data. At the same time, I was trying to find a balance to my own subjective position, assumptions and biases. Utilising the data to ground themes and then supplementing the understanding of these themes with literature from wider critical and postcolonial literature helped me to try and balance these different factors, however this was by no means perfect and will be an ongoing process in considering this research and any further work that evolves from it.

## **4.5 Implications**

The implications of these findings will now be highlighted, considering different levels which may help influence the experience of Muslim service users when accessing care.

### **4.5.1 Implications for Professional Bodies and Training**

Mental health professional bodies often highlight the need for professionals to be responsive to the diverse cultural and religious experiences of service user (Nursing & Midwifery Council, 2015; BPS, 2018, Royal College of Psychiatry, 2018). However, participants in this study echo research which highlights that opportunities to develop such skills are not consistently available or prioritised in professional training programs (Patel, 2004; Allan, 2017).

Specific teaching about different religions or spiritual and cultural frameworks for understanding mental health, especially related to Islam given its growing presence in the



UK, may be helpful in providing professionals foundational information about ideas that exists and that they may encounter from service users about distress, and a standard for what their training requires them to be aware of. The very inclusion of such ideas into professional learning environments may model and normalise the acknowledgement, consideration and inclusion of these ideas into professionals' own practice. Similarly, ensuring workforce diversity matches populations being served by professionals may be another way of modelling inclusion and normalising inclusion and diversity. This may be seen as part of a wider 'decolonisation' of mental health education, in order to eradicate the deleterious effect that ideological power structures, such as the 'absent standard' in mental health, have on the needs and experiences of people from minoritised backgrounds (Sakamota, 2007; Wood & Patel, 2017).

However, as noted by participants, professionals need reflective spaces in which to consider issues of difference, privilege and power. Such reflexivity is seen as a core competence in many professions (Nursing & Midwifery Council, 2015; BPS, 2018, Royal College of Psychiatry, 2018), however maintaining this in practice, in face of some people's unwanting or unwillingness to engage with such dialogues (Lowe, 2014) needs to be considered and managed. As noted in this research, this may be especially important due to the re-enactment of socially unequal dynamics that can occur in such spaces, which have consequences on professionals from minoritised backgrounds, who often report feeling responsible for keeping these issues on the agenda (Adetimole, Afuape & Vara, 2005; Mistry & Latoo, 2009).

#### 4.5.2 Implications for Services

This study outlined ways that services themselves may exclude Muslim service users, due to their lack of reflexivity about how they may be inaccurately constructing Muslim service users and the inflexibility in how services provide mental health interventions.

Services may then consider ways of introducing training for staff which helps them consider and counter some of the assumptions and discourses they draw upon when considering Islam, as well as how their own values and ideas may dominate in their approach to Muslim service users. As noted in the research findings, cultural competence training has been criticised for its over-generalising of 'difference' and a lack of consideration in self-reflexivity (Truong, Paradies & Priest, 2014). Therefore, including self-reflective components to such training is

necessary and highlighting specific salient narratives about Islam and how it is commonly construed may be important additions.

Co-produced training with Muslim organisations or Muslim service users may also provide a space where Islamic experiences and ideas can be heard and respected. However, consideration in how such contacts may be developed need to be careful to ensure that they do not reinscribe an unequal hierarchy by expecting Muslims to ‘assimilate’ or defend their contributions (Harris & Hussein, 2018) or provide reassurance to socially privileged groups about Islamophobic misjudgements (Saguy and Kteily 2014).

The lack of integration between mainstream services and local communities was highlighted by professionals, reflecting a hesitation from services to consider or include different ideas about mental health. Indeed, research has shown resistance to working with faith-based organisations (Durà-Vilà, Hagger, Dein, & Leavey, 2011), despite the substantial role such organisations play in providing mental health support to communities (Meran & Mason, 2019). However, where examples were provided by participants of them bridging this gap this appeared to facilitate improved relations between professionals and Muslim service users and communities.

Services may then consider ways of building relationships with local faith and community groups and consider ways of integrating the range of different understandings of mental health, including psychological, medical, spiritual and cultural frameworks into care provision through such relationships. Good examples of these are available (Maynard, 2008; Kovandžić et al., 2012; Cardo, 2014; Byrne, Mustafa, & Miah, 2017) and highlight the need for services to be localised and responsive to the needs of local populations, which shows awareness and respect for the religio-cultural diversity of Muslims.

#### 4.5.3 Implication for Future Research

This research has highlighted the way that prevalent social discourses may permeate into mental health spaces and affect the way that professionals and services respond to Muslim service users, based in the way that Islam is racialised and storied in the West. However, this could be more explicitly and thoroughly examined in future research with professionals by utilising analysis such as Foucauldian Discourse Analysis, or other deductive analytic approaches, which examine the influence power dynamics and social discourses on how

social groups are discursively constructed. Emerging from this study is that there may be a number of discourses which professionals may deploy in deriving their judgement, including themes of Orientalism, professional discourses around conceptualising ‘mental health’ and discourses around ‘professionalism’. Further exploration of how these ideas are constructed may be an area of future research.

Research looking into the role of difference, ‘othering’ and the effects that this may have on the dehumanising of service users and subsequent empathy or compassion provided to them by professionals and services may be another avenue for further research. A reflection from the research process, which proved difficult to quantify from the data, and to untangle from my personal connection to the research, was a sense that there may be an affective difference in the way that Muslim service users were discussed by different professionals. Whilst this observation may be related to many factors, some research has indicated the role in Islamophobia in dehumanising Muslims (Varvin, 2017) and how this dehumanisation can reduce empathy and compassion towards Muslims (Bruneau, Kteily & Laustsen, 2018; Gómez-Martínez & Moral-Jiménez, 2018) in research with refugees. Therefore, researching whether there is any link between Islamophobia, dehumanisation and mental health care access could also be a point of future research interest.

#### **4.5 Conclusion**

This research set out to understand what influences professionals’ understanding of Islam and how these different understandings and influences may go on to affect the way they provide care to Muslim service users. The research found that wider issues of Eurocentricity and secularity in Western mental health frameworks and approaches also played a part in marginalising the religious or cultural needs of Muslim service users, where these deviated from the ‘absent standard’. However, prevailing negative and essentialising social discourses about Islam were also seen to permeate into ideas about Muslims in professionals’ minds and these discourses were seen to prime negative association to Muslim service users’ beliefs or practices in times of professionals’ uncertainty or unfamiliarity, leading them to be constructed as limiting or problematic. Whilst awareness of the unique context for Muslims in the West at present were present in participants accounts, there was limited consideration of the effects of these on their own judgements and practice and a discomfort was expressed about discussing issues of ‘difference’ and ‘marginalisation’.

However, some participants noted the benefits of having closer encounters with Islam in helping them to “demystify” the religion and examples were provided attempts some professionals had made to enter Muslim service users’ contexts and frames of reference and build relationships faith organisations or communities.

This research has implications for the need to challenge the misconceptions about Islam in mental health education and training and in fostering more open and inclusive ways of understanding and responding to distress, by collaborating with Muslim communities and faith organisation in a way that is co-produced and mindful of the inequalities and power imbalances that exist across different identities and beliefs.

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## **6. APPENDICIES**

**Appendix A. Systematic Review Outline & Summary of Identified Articles**

**Appendix B. Approved UEL Ethics Application**

**Appendix C: Participant Information Sheet**

**Appendix D. Participant Consent Form**

**Appendix E. Participants Debrief Form**

**Appendix F. Participant Recruitment Poster**

**Appendix G. Participant Demographics Request Email**

**Appendix H. Table 1. Participants Demographics**

**Appendix I. Semi-Structured Interview Schedule**

**Appendix J. Transcription Convention**

**Appendix K. Initial Codes List**

**Appendix L. Extract of Coded Transcript**

**Appendix. M. Thematic Map of Candidate Themes**

**Appendix N. Final Thematic Map & Excerpt of Process of Refining Themes**

**Appendix O. Themes, Subthemes, Coding & Extracts Framework**

**Appendix P. Description of Themes & Relevance to Research Question**

**Appendix Q. Reflective Diary Extract**

## **Appendix A. Systematic Review Outline & Summary of Identified Articles**

Systematic Review- Professional Judgements & Islam (conducted on 28.7.2020)

Search Terms:

("professional judgements" OR "professional attitudes" OR "professionals" OR "mental health professionals") AND ("mental health" OR "psychological" OR "psychiatric" OR "emotional wellbeing" OR "distress") AND ("Islam" OR "Muslim" OR "Islamic" OR "Muslim-like") AND ("British" OR "UK" OR "United Kingdom" OR "Britain")

Database	Search terms	References found	Limiters
EBSCO: including Academic search Complete, CINAHL Plus, PsychINFO	("professional judgements" OR "professional attitudes" OR "professionals" OR "mental health professionals") AND ("mental health" OR "psychological" OR "psychiatric" OR "emotional wellbeing" OR "distress") AND ("Islam" OR "Muslim" OR "Islamic" OR "Muslim-like") AND ("British" OR "UK" OR "United Kingdom" OR "Britain")	108 with duplicates removed  7 relevant	-English language only  -Publication date 01/01/1995-31/01/2020)  -Source type: academic journals, journal articles, dissertations
Science Direct	(judgements OR attitudes) AND ("mental health") AND (Islam OR Muslim OR Islamic) AND (UK OR "United Kingdom" OR Britain)	597 4 relevant (3 repeats of ones found in Ebsco search)	English language only  -Publication date 01/01/1995-31/01/2020)  -Source type: academic journals,

			journal articles, dissertations
Scopus	TITLE-ABS-KEY ( ( "professional judgements" OR "professional attitudes" OR "professionals" OR "mental health professionals" ) AND ( "mental health" OR "distress" ) AND ( "Islam" OR "Muslim" OR "Islamic" ) AND ( "UK" OR "Britain" OR "United Kingdom" ) )	18 3 relevant (2 repeats of ones found in Ebsco search)	-Title, Abstract, Keywords  English language only  -Publication date 01/01/1995-31/01/2020)  -Source type: academic journals, journal articles, dissertations

Inclusion criteria for selecting relevant literature:

1. Included references to Islam or Muslim or ‘Muslim-like’ people
2. Included reference to mental health or mental health care/services
3. Research based in United Kingdom
4. Quantative or qualitative research incl. published articles, academic dissertations or reviews
5. Relevance to research topic- reference to professional’s judgements or attitudes towards Islam in paper.

The identified literature was screened for relevance in the titles, abstracts and the body of the text, using the inclusion criteria highlighted above. 9 relevant papers were identified after removing 5 duplicates.

Author(s)	Date	Title	Summary
Hassan, S. M., Leavey, C., Rooney, J. S., & Puthussery, S.	2020	A qualitative study of healthcare professionals’ experiences of providing maternity care for Muslim women in the UK	12 semi-structured one-to-one qualitative interviews with Healthcare Practitioners in NHS maternity unit in the North West of England.  Findings: -understanding of some religious values and practices related to Muslim women, such as fasting the month of Ramadhan

			<p>- expressed stereotypical beliefs about Muslim women, including ‘concern’ about the extent to which they felt Muslim women made their own decisions, describing them as shy</p> <p>-difficulty managing aspects of religious beliefs e.g. expressing intolerance of ‘inflexibility’ in beliefs and struggles with concept of ‘fate’.</p>
Jadhav, S. S.	2004	Sensitising mental health professionals to Islam.	<p><u>Procedure:</u> Questionnaire was given to 5 London based inpatient mental health to elicit staff knowledge on Islam, including qualitative data.</p> <p>A tailored day long workshop was subsequently conducted at the Regent's Park Mosque for each of teams</p> <p><u>Findings:</u> -Quantitative analysis of pre and post workshop questionnaire showed an improvement in correct response on 63.5% of the 52 items. Four items showed a statistically significant improvement - Professionals expressed confusion over providing a Halal diet, prayer times, facilities and availability of the Holy Qur’an, confusion over administering medication during Ramadan -Professionals referenced subordinate status of Muslim women and the gendered stigma of mental illness -Professionals highlighted language and communication difficulties</p>
Mir, G., & Sheikh, A.	2010	“Fasting and prayer don’t concern the doctors...they don’t even know what it is”: communication, decision-making and perceived social relations of Pakistani Muslim patients with long-term illnesses	<p><u>Procedure:</u> In-depth interviews and ethnographic study. Seventeen semi-structured interviews (including seven with ‘influential professionals’) and 12 observations of healthcare settings</p> <p><u>Findings:</u> ‘-Practitioners unwilling to engage in discussion about religious influences on patient decision-making, reflecting</p>

			<p>professionals' lack of awareness of their importance.</p> <p>-Patients consequently receive little or no support from professionals about decisions involving such influences on self-care.</p> <p>-Policy vacuum and lack of discussion leads to the use of stereotypes of Pakistani Muslims which are unchallenged in most healthcare settings, reflecting wider social dynamics in UK society</p> <p>-Negative impact on psychosocial well-being of Pakistani Muslims and on their ability to manage long-term conditions.'</p>
Worth, A., Irshad, T., Bhopal, R., Brown, D., Lawton, J., Grant, E., ... & Sheikh, A.	2009	Vulnerability and access to care for South Asian Sikh and Muslim patients with life limiting illness in Scotland: prospective longitudinal qualitative study.	<p><u>Procedure:</u> Included interviews with 20 key health professionals working with South Asian Sikh and Muslim patients.</p> <p><u>Findings:</u> "Barriers among professionals included: -Lack of cultural awareness and understanding of needs -Fear of making a cultural blunder - Cultural assumptions, particularly about family -Lack of effective cultural awareness or training in diversity -Institutional discrimination and direct racism - Language barriers and inability to access interpretation services at short notice -Inflexible services"</p>
Burr, J.	2002	Cultural stereotypes of women from South Asian communities: mental health care professionals' explanations for patterns of suicide and depression	<p><u>Procedure:</u> Focus groups with a range of mental health care professionals from Inner London Inpatient and Outpatient mental health care services</p> <p>Individual interviews with consultant psychiatrists and GPs</p> <p><u>Findings:</u> "Mental health care professionals constructed cultural difference in terms of fixed and immutable categories which operated to inferiorise Britain's South Asian communities. It is argued that their knowledge is constructed upon stereotypes of western</p>



			culture as superior to a construction of eastern cultures as repressive, patriarchal and inferior to a western cultural ideal. Ultimately, it is argued that these stereotypes become incorporated as ‘fact’ and have the potential to misdirect diagnosis and therefore, also misdirect treatment pathways.”
Mistry, H., Bhugra, D., Chaleby, K., Khan, F., & Sauer, J.	2009	Veiled communication: is uncovering necessary for psychiatric assessment?	<p><u>Procedure:</u> Email survey of psychiatrists and psychologists across the world -16 responses Asked whether wearing of the Niqab worn by Muslim women may pose a clinical dilemma for the psychiatric assessment and whether clinical judgment is thought to be affected if full facial expressions are not accessible</p> <p><u>Findings:</u> “Nine out of 11 believed clinical assessment may be compromised, although respondents were aware of cultural sensitivity around the issue. Two out of 11 however, felt fully able to assess the mental state of a veiled woman.</p> <p>Some professionals reported that they feel unable to assess or treat if the request to take the veil off is declined”</p> <p>UK based professionals in this study declined for their data to be included in the reporting of the study’s finding which was linked by the authors to the socio-political narratives about whether or not to ban the niqab in the UK that were occurring at that time.</p>
Laird, L. D., De Marrais, J., & Barnes, L. L.	2007	Portraying Islam and Muslims in MEDLINE: A content analysis	<p><u>Procedure:</u> Ethnographic content analysis of 2342 OVID MEDLINE-indexed abstracts from 1966 through August 2005, derived from a Boolean search for “islam or muslim or muslims.”</p> <p><u>Findings:</u> “Latent (underlying) themes implied that being an observant Muslim poses health risks; Muslims are negatively affected by tradition and should adopt modernity; and that “Islam” is a problem for biomedical healthcare delivery. A countervailing latent theme implies that being Muslim may promote good health”</p>

Younis, T., & Jadhav, S.	2019a	Islamophobia in the National Health Service: an ethnography of institutional racism in PREVENT's counter-radicalisation policy.	<p><u>Procedure:</u> Frame analysis drawing on 2 years of ethnographic fieldwork including observations in PREVENT training and interviews with NHS staff.</p> <p><u>Findings:</u></p> <p>“Demonstrates how Prevent engages in performative colour-blindness – the active recognition and dismissal of the race frame which associates racialised Muslims with the threat of terrorism and how racialised policies like PREVENT impact the minutia of clinical interactions; how the pretence of a ‘post-racial’ society obscures institutional racism”</p>
Younis, T., & Jadhav, S.	2019b	Keeping our mouths shut: the fear and racialized self-censorship of British healthcare professionals in PREVENT training.	<p><u>Procedure:</u> Individual interviews with 16 NHS professionals who participated in mandatory PREVENT counter-radicalisation training, half were Muslims</p> <p><u>Findings:</u></p> <ul style="list-style-type: none"> <li>-Self-censorship healthcare staff.</li> <li>-Fear to criticise PREVENT, especially for Muslim staff.</li> <li>-Conditions affecting NHS which overwhelm staff with other concerns.</li> </ul>
Kovandžić, M., Funnell, E., Hammond, J., Ahmed, A., Edwards, S., Clarke, P., ... & Dowrick, C.	2012	The space of access to primary mental health care: a qualitative case study.	<p><u>Procedure:</u> Focus groups with local residents from local Somali minority and health professionals, and ethnographic mapping and observation in local community settings and primary care teams in Liverpool.</p> <p>Datasets generated over a 3-year period (2008–2010)</p> <p><u>Findings:</u></p> <ul style="list-style-type: none"> <li>-3<sup>rd</sup> sector professionals critical of Western medical, pathological models of mental health</li> <li>-Discussed “need for de-centring and re-connecting the role of medical professionals within primary care</li> </ul>

			-Endorsement of multiple avenues of access to diverse support and intrepid communication among all involved actors”
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## **Appendix B. Approved UEL Ethics Application**

### **UNIVERSITY OF EAST LONDON School of Psychology**

## **APPLICATION FOR RESEARCH ETHICS APPROVAL FOR RESEARCH INVOLVING HUMAN PARTICIPANTS**

### **SECTION 1. Your details**

**1. Your name:**

Sara Al-Alaway

**2. Your supervisor’s name:**

Dr David Harper

**3. Title of your programme:**

Professional Doctorate in Clinical Psychology (DClinPsych)

**4. Submission date for your Doctoral research:**

May 2020

**5. Please tick if your application includes a copy of a DBS certificate (see page 3)**

☐

**6. Please tick if your research requires DBS clearance but you are a Prof Doc student and have applied for DBS clearance – or had existing clearance verified – when you registered on your programme (see page 3)**

☐

**7. Please tick if you need to submit a DBS certificate with this application but have emailed a copy to Dr Tim Lomas for confidentiality reasons (Chair of**

☐

the School Research Ethics Committee) [t.lomas@uel.ac.uk](mailto:t.lomas@uel.ac.uk)

- 8. Please tick to confirm that you have read and understood the British Psychological Society's Code of Ethics and Conduct (2009) and the UEL Code of Practice for Research Ethics (See links on page 1)**

X

## **SECTION 2. About your research**

### **9. What your proposed research is about:**

**‘How do mental health practitioners consider and understand identities, beliefs and practices that are associated with Islam, when encountered in clinical practice’**

I am conducting research to explore rich interview data derived from mental health professionals about their experiences of working with service users who have identities, beliefs or practices linked to the religion of Islam.

The study aims to:

- explore how mental health practitioners derive information about a person's Islamic identity, beliefs or practices when working with service users
- to explore how practitioners consider and understand Islamic identity, beliefs or practices and how this informs their practice.
- to consider what individual and systemic or societal factors may contribute to the way Islam is being considered and understood by practitioners.

This study hopes to support professionals and services to better understand how it is meeting the needs of this particular client group. It hopes to identify areas of strength in understanding or practice as well as identifying areas requiring further consideration. This information hopes to be used to contribute to initiatives seeking to ensure that acceptable and appropriate service are being provided to service users who have identities, beliefs or practices linked to Islam.

### **10.Design of the research:**

This study will involve semi-structured interviews conducted with mental health professionals asking questions relating to the research questions. Interviews will be about 30-45 minutes in duration.

The data will then be analysed using qualitative methodology, Thematic Analysis, to derive emerging themes which will be interpreted in relation to critical discourse considerations.

## **10. Recruitment and participants (Your sample):**

The proposed research aims to conduct interviews with 15 mental health professionals, seeking to recruit 5 clinicians from three professions; clinical psychology, psychiatry and nursing, in order to build upon research findings regarding inter-disciplinary similarities and differences.

Naturally all participants will be over 18 due to the sample being used, and there is no upper limit on age. No demographic groups (e.g. gender, ethnicity) will be excluded as long as the person meets the criteria outlined below.

Participants will be requested to be London based for ease of data collection, however there may be scope to expand this if necessary, with possible skype interviews. Inclusion criteria requires that participants have some experience of working with service users they have perceived to have Islamic identities, beliefs or practices, to ensure rich data can be derived from clinical experiences of perceived encounters with Islam.

A voluntary sample will be recruited through independent professional networks such as via requests for advertising on popular social media accounts (e.g. UK based Clinical Psychologists) and/or informally through peers and personal networks, or through snowballing from recruited participants. This would be done using a social media accounts made specifically for the research including twitter, facebook and skype.

## **11. Measures, materials or equipment:**

An interview schedule will be created based on the research aims. This will be semi-structured with prompts asking for some specificities and illustrative examples.

The questions will focus on how Islamic identity, beliefs or practices are identified by professionals; what ideas professionals have about how these factors interact with mental health; whether these are considered in shaping the interventions delivered; what helps support working with this population; and how professionals relate to working with this service user group. (Please see draft interview schedule in Appendix. 1).

## **12. If you are using copyrighted/pre-validated questionnaires, tests or other stimuli that you have not written or made yourself, are these questionnaires and tests suitable for the age group of your participants?**

NA

## **13. Outline the data collection procedure involved in your research**

Participants will be recruited as detailed above and asked to contact me should they wish to consider participation further.

Participants will be provided with a research information sheet communicating to them the details of the study and what will be required of them (see Appendix 2). If they meet the requirements of participation, they will be invited to attend a 30-45 minute interview.

Interviews will be conducted either via Skype or at UEL Stratford campus. The choice is provided in order to create convenience for interviewees. Participants will be advised from the beginning that an audio-recorder will be used to record interviews and facilitate transcription.

### **SECTION 3. Ethical considerations**

#### **14. Fully informing participants about the research (and parents/guardians if necessary):**

Participants will be given an information sheet regarding the research (see Appendix 2). This document will be written in clear English, ensuring it is age appropriate and accessible to the target sample. It will contain clear information about what participation in the study involves.

#### **15. Obtaining fully informed consent from participants (and from parents/guardians if necessary):**

A consent form (see Appendix 3) will be required to be signed before interviews commence. This document will be written in clear English, ensuring it is age appropriate and accessible to the target sample. It will contain clear information about what participation in the study involves

#### **16. Engaging in deception, if relevant:**

The proposed research involves no deception.

#### **17. Right of withdrawal:**

Participants will be advised of their right to withdraw from the research study at any time before a specified date in which analysis has commenced. It will be stated that withdrawal will cause no disadvantage to them and will not affect their professional credibility in any way. Furthermore, participants will be assured that they are not obliged to give any reason for their wish to withdraw. This will be made clear to participants on the information sheet and consent form (see Appendix 2 & 3)

Withdrawing from the project would include deleting any audio recordings and interview transcripts if the participant indicated this was their wish.

Participants will be reminded following the interview of their right to withdraw consent, with respect to the possibility that the interview may have elicited things that had not been initially considered.

#### **18. Will the data be gathered anonymously?**

No

**19. If NO what steps will be taken to ensure confidentiality and protect the identity of participants?**

I, the researcher, will be the only person aware of the identities of the participants. Participants details will be stored on a password protected computer. All personally identifiable information will be removed from interview transcripts or any reports produced from this data set, including the assessed thesis document. Any paper documents, including consent forms, will be kept in a locked environment and not shared with anyone else. Names and contact details of participants will be destroyed immediately after the successful examination of the thesis.

Confidentiality will be protected as much as possible by using participant codes and any potentially identifying references that could identify a person will be obscured in interview transcripts. Extracts in the final thesis and any resulting publications will only contain this anonymised data.

Audio recording files will be stored on a password-protected computer and deleted within 3 weeks after the successful examination of the thesis. Only the researcher will have access to these files. Anonymised transcripts will be stored on the same password protected computer, and only the researcher, Supervisors and Examiners will have access to these transcripts. Transcripts will be kept for 5 years after successful examination of the thesis, to allow for publications, and then deleted.

Participants will be informed that confidentiality may need to be broken if anything they say gives the researcher cause to believe someone may be at risk of harm. Advice from the thesis supervisor will be sought in a such an occurrence.

**20. Will participants be paid or reimbursed?**

No

**If YES, why is payment/reimbursement necessary and how much will the vouchers be worth?**

**SECTION 4. Other permissions and ethical clearances**

**21. Research involving the NHS in England**

**Is HRA approval for research involving the NHS required?** YES

**Will the research involve NHS employees who will not be directly recruited through the NHS and where data from NHS employees will not be collected on NHS premises?**  
YES

**If you work for an NHS Trust and plan to recruit colleagues from the Trust will permission from an appropriate member of staff at the Trust be sought and is a copy of this permission (can be an email from the Trust) attached to this application? N/**

**22. Permission(s) from an external institution/organisation (e.g. a school, charity, workplace, local authority, care home etc.)?**

**Is permission from an external institution/organisation/workplace required? NO**

**If YES please give the name and address of the institution/organisation/workplace:**

**23. Is ethical clearance required from any other ethics committee?**

No

**If YES please give the name and address of the organisation:**

**Has such ethical clearance been obtained yet?**

**If NO why not?** Currently in application process, pending outcome.

**If YES, please attach a scanned copy of the ethical approval letter. A copy of an email from the organisation confirming its ethical clearance is acceptable.**

**SECTION 5. Risk Assessment**

**24. Protection of participants:**

There are no anticipated risks of harm to participants.

I, the researcher, will look out for any signs of concern from participants during the interview process. If I detect any sign of distress I will offer the participant an opportunity to take a break and attempt to establish any needs they may have, including revisiting their right to withdraw and confidentiality information as appropriate. We may resume the interview process only should they wish.

Participants are ensured anonymity and confidentiality without threat to their professional reputation. This is mentioned before participation and will be revisited in the debrief. I will ensure consent is continually revisited in this way through the process of participation.

**25. Protection of the researcher:**

I as the researcher will be attending interviews with participants alone, potentially off site. To ensure my safety I will ensure that my supervisor is aware of where and when interviews will be taking place. I will carry a mobile phone with me and make contact with my supervisor following the interview, should the interview take place off site, to communicate that my safety has been ensured.



Where possible I will try to conduct interviews at a site where others are present, during working hours. If research is conducted off site at NHS buildings, local health and safety procedures will be identified and followed.

## **26. Debriefing participants:**

Participants will be given time at the end of the interview to ask any questions that had emerged from taking part. There is no deception involved in the study therefore no further information is provided, other than reminder of my contact details and when to expect to be able to access the study report and how to find this.

Participants will be reminded of what will happen to the data and where they can find information once the project is complete and asked if they are still happy to take part in the study, reminded of their rights to withdraw consent (see Appendix 4 for participant debrief form)

## **27. Other: n/a**

## **28. Will your research involve working with children or vulnerable adults?\***

No

**If YES have you obtained and attached a DBS certificate?**

N/A

**If your research involves young people under 16 years of age and young people of limited competence will parental/guardian consent be obtained.**

N/A

**If NO please give reasons. (Note that parental consent is always required for participants who are 16 years of age and younger)**

## **29 Will you be collecting data overseas?**

NO

**If YES in what country or countries (and province if appropriate) will you be collecting data?**

## **SECTION 6. Declarations**

**Declaration by student:**

*I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.*

Student's name: *Sara Al-Alaway*

Student's number: XXXXXXXX  
2019

Date: 26<sup>th</sup> March

**Supervisor's declaration of support is given upon their electronic submission of the application**

**UNIVERSITY OF EAST LONDON  
School of Psychology**

**REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION**

**FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS**

**Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.**

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Tim Lomas (Chair of the School Research Ethics Committee. [t.lomas@uel.ac.uk](mailto:t.lomas@uel.ac.uk)).

**HOW TO COMPLETE & SUBMIT THE REQUEST**

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. When submitting this request form, ensure that all necessary documents are attached (see below).
4. Using your UEL email address, email the completed request form along with associated documents to: Dr Tim Lomas at [t.lomas@uel.ac.uk](mailto:t.lomas@uel.ac.uk)
5. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.
6. Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

**REQUIRED DOCUMENTS**

1. A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.
2. Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter,

updated consent form etc.

3. A copy of the approval of your initial ethics application.

Name of applicant: Sara Al-Alaway

Programme of study: Professional Doctorate in Clinical Psychology

Title of research: How do mental health practitioners consider and understand identities, beliefs and practices that are associated with Islam when encountered in clinical practice.

Name of supervisor: Dr David Harper

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
Section 1, bullet point 1. Your name	Change of researcher's surname
Section 2, bullet point 9- Change of name of project	To improve clarity of project title and ensure registered title matches approved ethics approval application.
Section 2, bullet point 10- page 3  slight adaptation to recruitment procedures	No longer seeking to recruit through NHS therefore removal of NHS options
Bullet point 23-  No to other ethical approval needed	No longer seeking to recruit through NHS

Removal of info about that below	
----------------------------------	--

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	X	

Student's signature (please type your name): SARA AL-ALAWAY

Date: 22/05/2020

TO BE COMPLETED BY REVIEWER		
Amendment(s) approved	YES	
<p style="text-align: center;"><b>Comments</b></p>		

Reviewer: Tim Lomas

Date: 22.5.20

## **Appendix C: Participant Information Sheet**

### **Participant Information Sheet**



**‘How do mental health practitioners work with identities, beliefs and practices associated with Islam when encountered in clinical practice.’**

### **PARTICIPANT INVITATION LETTER**

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

#### **Who am I?**

I am a Trainee Clinical Psychologist at the University of East London. This study is being carried out as part of my professional training.

#### **What is the research about?**

It will explore the experiences of mental health professionals when working with service users who are associated with the religion of Islam. By doing so, this study hopes to further our understanding of how this populations’ needs are being met and how services can be further supported in doing this.

#### **Who can participate?**

I would like to interview five mental health nurses, five psychiatrists and five clinical psychologists who have had experience working clinically with service users who are associated with Islamic identities, beliefs or practices. No specialist knowledge is required.

#### **What will your participation involve?**

Being interviewed by me for no more than 45 minutes. You will be asked about your clinical experiences of working with service users who are associated with Islam.

The interviews can be conducted via Skype or at the University of East London Stratford Campus.

#### **What will happen to the information that you provide?**

The interviews will be recorded as audio files which will be stored in a password-protected file on a password-protected computer.

I will type up the interviews but will change information which might identify you personally (e.g. names of people or places). I will use only anonymised extracts from interviews when I write up the study for my thesis or articles for scientific journals. Only I will know who has been interviewed.

My supervisors and examiners will have access to anonymised transcripts of the interviews. I will retain recordings until I have successfully passed the examination. I will retain the anonymised transcripts for five years to allow for publication of the results.

**Will taking part in this research be safe and confidential?**

What you say in the interview will remain confidential except in the unlikely event that you disclose something indicating that you or someone else is at immediate risk of serious harm.

As the interview is about topics within normal professional duties it is extremely unlikely there will be any distress, though some discomfort may be possible. In such an instance we can take a break from the interview or it can be terminated at any time.

**Do I have to take part? Can I withdraw at a later stage?**

You are quite free to decide whether or not to participate and should not feel coerced. You are free to withdraw from the study any time up to February 1<sup>st</sup> 2020 when I will be analysing the results.

**Contact Details**

Sara Al-Alaway

Email: XXXXXXXXXXXX or Telephone :XXXXXXXXXX

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr David Harper at the School of Psychology, University of East London, Water Lane, London E15 4LZ,  
Email: [D.harper@uel.ac.uk](mailto:D.harper@uel.ac.uk)

**or**

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ.  
(Email: [t.lomas@uel.ac.uk](mailto:t.lomas@uel.ac.uk))

## **Appendix D. Participant Consent Form**

### **UNIVERSITY OF EAST LONDON**



#### **Consent to participate in a research study**

*'How do mental health practitioners work with identities, beliefs and practices associated with Islam when encountered in clinical practice.'*

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study before February 1<sup>st</sup> 2020 without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw after data analysis has begun, the researcher reserves the right to use my anonymous data.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

.....

Date: .....

## Appendix E. Participants Debrief Form

**‘How do mental health practitioners work with identities, beliefs and practices associated with Islam when encountered in clinical practice.’**



Thank you for your participation in this study.

This study has aimed to explore how mental health professionals work with service users who are associated with Islam. It has sought to understand how these associations are identified by mental health professionals and what may influence the way professionals then go on to work with this population. The aim of doing this has been to help inform how we are currently meeting the needs of this service user group and where there may be scope for development; in order to enhance the accessibility and acceptability of these services for this population.

Your interview data will now be transcribed, with all personally identifiable information taken out to ensure your anonymity. If you would like to withdraw your data from this study, you have until February 1<sup>st</sup> 2020 to do so. At this point data analysis will commence and the researcher will reserve the right to use you anonymised data to inform this research.

This research will be examined as a doctoral thesis and may further go on to be published. Audi recording will be kept until successful examination of the thesis and anonymised transcripts will be kept for 5 years following this to allow for publication.

If you would like updates about this research or have any questions you would like to raise please contact me or my thesis supervisor on the details below.

Thank you for your time.

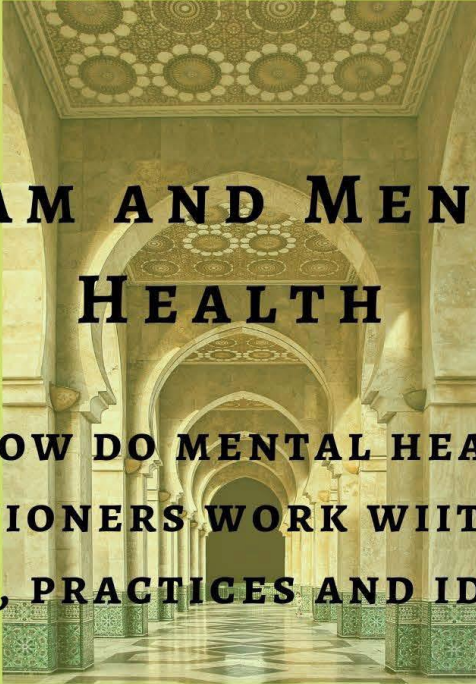
Sara Al-Alaway

Email: XXXXXXXXXXXX or Telephone :XXXXXXXXXX

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr David Harper at the School of Psychology, University of East London, Water Lane, London E15 4LZ,  
Email: D.harper@uel.ac.uk



## **Appendix F. Participant Recruitment Poster**



# **ISLAM AND MENTAL HEALTH**

## **HOW DO MENTAL HEALTH PRACTITIONERS WORK WITH ISLAMIC BELIEFS, PRACTICES AND IDENTITIES?**

ISLAM IS THE SECOND LARGEST RELIGION IN THE UK, HOWEVER MUSLIM SERVICE USERS HAVE BEEN SHOWN TO HAVE POORER ACCESS TO MENTAL HEALTH SERVICES.


THIS STUDY HOPES TO LEARN FROM A RANGE OF MENTAL HEALTH PRACTITIONERS ABOUT THEIR EXPERIENCES OF PROVIDING MENTAL HEALTH CARE TO THIS POPULATION; WHAT IS WORKING WELL AND WHERE THERE ARE AREAS IN NEED OF DEVELOPMENT.

<b>WHO CAN TAKE PART?:</b>	<b>WHAT WILL TAKING PART INVOLVE?:</b>
MENTAL HEALTH NURSES, PSYCHIATRISTS AND PSYCHOLOGISTS WHO HAVE WORKED WITH SERVICE USERS THAT THEY HAVE PERCEIVED TO HAVE BEEN MUSLIM OR TO HAVE HAD IDENTITIES LINKED TO ISLAM IN ANY WAY.	PARTICIPANTS WILL BE ASKED TO TAKE PART IN A ONE TO ONE INTERVIEW, LASTING 30-40 MINUTES, AT A PLACE OF CONVENIENCE OR OVER SKYPE

(NO SPECIALIST KNOWLEDGE OR AMOUNT OF EXPERIENCE IS REQUIRED)

**CONTACT:**

IF YOU WOULD LIKE MORE INFORMATION AND/OR YOU WOULD LIKE TO TAKE PART IN THE STUDY, PLEASE CONTACT SARA ON

 **University of**

## **Appendix G. Participant Demographics Request Email**

Hello,

Thank you for expressing interest in this research study looking into how mental health practitioners work with Islamic beliefs, practices and identities.

This study is hoping to recruit a diverse range of participants from each profession, in order to capture the range of experiences that exist within these group. For that reason, I kindly ask whether you would be happy to provide some further brief information about yourself in order to support the recruitment process. If you are not happy to answer any of these questions, then please feel free to state that or leave it empty.

Ethnicity:

Gender:

Religion:

Location:    London ☐                      Other ☐    (please state region).....

Service area (e.g. Older adults, inpatient, LD...):

Years since professional qualification:    Up to 5 years ☐

5-10 years                      ☐

10-15 years                   ☐

Over 15 years                ☐

Have you attended any professional training relating to the research

topic?.....  
.....  
.....

How much have you thought about issues relating to race, religion an difference in relation to mental health care

provision?.....  
.....  
.....

By receiving this information from you I will understand that you are still interested in participating in this study. Thank you for your interest and I will be in contact again very soon with further updates regarding participation.

Kindest Regards

Sara

Trainee clinical Psychologist

University of East London

## **Appendix H. Table 1. Participants Demographics**

Participant ID	Gender	Profession	Ethnicity	Religion	Location	Service Area	Years Post-Qualification	Specific Training in Research Topic	Experience considering race, religion and difference in mental health care
P1	Female	Psychiatry Trainee	White-British	Not stated	London	Not stated	Not stated	Not stated	Not stated
P2	Male	Mental Health Nurse	White-British	Greek Orthodox	London	Not Stated	15-20 years	Not stated	Not stated
P3	Male	Psychiatry Trainee	White-Other	Atheist	London	Child and adolescent services	5-10 years	none	none
P4	Female	Psychiatry	Not stated	Not stated	London	Not stated	2 years into psych training	Not stated	Not stated
P5	Female	Clinical Psychologist	White-Other	None (raised Christian)	Oxford	Learning Disabilities	5-10 years	None stated	None stated
P6	Male	Psychiatry Trainee	Chinese	Atheist	London	Children & adolescent Services	5-10 years	None	none

P7	Female	Clinical Psychologist	British Asian	Islam	Birmingham	Looked After Children (LAC)	5-10 years	None	BAME leadership training
P8	Male	Mental Health Nurse	White-Other	Roman Catholic	London	Adult CMHT	5-10 years	None	None
P9	Female	Clinical Psychologist	White-British	Atheist	London	CAMHS	1-5 years	None	Some considerations in professional training
P10	Female	Mental Health Nurse	British-Asian	Christianity	London	Adult CMHT	1-5 years	No	Some consideration in work
P11	Female	Clinical Psychologist	White-British	None (raised Anglican Christian)	London	LD/ Mainstream Adult Services	10-15 years	Yes, including with Home Office	Yes, “very relevant to my work”

## **Appendix I. Semi-Structured Interview Schedule**

### **Draft Interview Schedule**

-How have you identified Islam as part of a service user's identity or beliefs in the people you have worked with?

*(probes: -what was said about it? did/how found out more?)*

- Did you feel that their Islamic identity /beliefs/ practices interacted with their mental health?

*(probes: any challenges? positives? how did that connect to the religion?)*

-Did their Islamic faith and culture influence their understanding of mental health?

*(probes: how did this match your ideas personally or professionally, did this match with the service/intervention?)*

-Do you feel that their Islamic identity/beliefs/practices influenced the work you did with the service users?

*(probes: in what ways? did their needs match the work? how about in the wider team or service? how was it different to someone who wasn't Muslim/not Islam)*

-How did you relate to the service user's Islamic identity/beliefs/practices?

*(probes: how compare with your own ideas? either professionally or personally? what influences that, personal experiences/wider context?)*

-What do you think has helped you when working with Muslims or Islamic identity/beliefs/practices in your practice?

Probes: training, CPD, other sources? professional/ personal

-What do you think could support you work with Muslim/Islamic service users?

*(what's been helpful? what good practice have you seen/drawn on? whats missing?)*

## Appendix J. Transcription Convention

Personally identifiable information and sensitive details (such as names of services or cities) were replaced with a broad description of the reference, in order to maintain confidentiality and anonymity of the participant.

Minor amendments were made to participants' accounts if they were selected as transcript extracts in the Results chapter, to improve the readability of the extract, such as deleting repeated words or utterances (e.g. errr, um).

The following symbols were used in the transcript to represent features of the speech:

...	Significant pause in speech
{...}	Omissions in speech to shorten extract
* _ *	Marking expressive behaviours e.g. *laughter* or *sigh*
[word]	Inserted by researcher to indicate what participant was referring to

## Appendix K. Intermediate Codes List

No.	Intermediate Codes
1	Passivity in acquiring information about Islam
2	(un)noticing assumptions
3	Presence of Orientalist assumptions
4	Active enquiry about Islam
5	Judgements of ‘importance’ (in considering Islam)
6	Resistance to considering Islam
7	Erasure of Islam
8	Reliance on visual indicators
9	Islam as “very present”
10	‘Traditionality’ as ‘Very Religious’
11	Essentialising Islam
12	Culture/Religion confusion
13	Linking multiculturalism and religion
14	Islam and all other differences
15	Conflating negatively perceived cultural practices to Islam
16	Professionals as White
18	Difficulty relating to Islam
17	Need for ‘openness’
18	Benefits of professional’s cultural difference (coloniality)
19	Traditionality vs acculturation in ‘understanding’ mental health
20	Islamic constructs of mental health as peripheral
21	Mental health OR cultural or spiritual beliefs
22	Not asking about understandings of mental health
23	Individualistic vs Collectivist approaches
24	Ideas of ‘guardedness’ of Islamic patients
25	Discomfort working with “very religious” or “traditional”
26	Islam-blind approaches
27	Perceived ineffectivity of psychological treatments
28	Preoccupations with risk in culturally different practices
29	Perceptions of rigidity inhibiting treatment outcomes
30	Idea that patients’ beliefs need to change
31	Attributing disengagement to religious or cultural practices
32	Superiority of western liberal individualism
33	Coloniality and interventionism
34	Balancing respect for difference with perceived professional role and responsibilities
35	Interpreting distress through Islamic difference
36	Stereotyping and punitive actions
37	Standardised care approaches
38	Focus on practical adaptations in ‘holistic’ care
39	Lack of discussion about ‘difference’ in services
40	Avoidance about discussions of ‘difference’
41	Impact of limited resources (on individualising care)
42	Questioning the appropriateness of universally applying Western approaches
43	Underrepresentation of Islamic patients in specialist services

44	Lack of diversity within MH professionals
45	Impact of securitisation of Islam on interaction with services
46	Psychologisation of spiritual frameworks of mental health
47	Differences amongst professional paradigms
48	Similarities amongst professional paradigms
49	Neutrality
50	Helpful/Unhelpful binaries
51	Familiarity & clinical judgements
52	Discrediting/devaluing religious and cultural frameworks
53	Utilising epistemologically consistent models
54	Religious/Cultural insiders
55	Awareness of limitations & reflexivity
56	(Moving towards) co-production
57	Contact with Islam as educational
58	Demystifying Islam
59	Learning from patients
60	Reports of discrimination experiences
61	The Oppressor-Oppressed binary
62	Impact of terrorism and media narratives
63	Mirrored experiences-staff and patients of Islamic backgrounds
64	Impact of training in working with Islam
65	Lack of specificity in diversity training and cultural competence
66	The wish to learn from people's experiences
67	Whiteness/Whitening in professional identity
68	Influence of personal experiences
69	Religious or Cultural exposure
70	Impact of cancel culture
71	Available narratives about Islam
72	Constructions of women as passive, oppressed and in need of liberation
73	Constructions of Islam as rigid, less developed and backwards
74	Constructions of mysterious, odd or suspicious
75	Discrepancies between media and reality
76	Subjugated narrative about being Islamic and Professional
77	The need to seek support out of profession
78	Threat of raising the agenda of inclusion



## Appendix L. Extract of Coded Transcript

Interview Transcript (from Line 10)	Code
<p><b>P3:</b> Well I guess the first the first source of information is the referral, when we talk about a new patient so erm I would look for this information about ethnic background that matches Muslim in the referral and most of the time if the patient is known to mental health services there will be a part of (electronic database) or (electronic database) where you can check ethnicity and sometimes it's just the surname or name that can makes me aware that there might be a non-British background and then I guess the next stage would be when I see a patient and there are some kind of signs that you can pick up the way they are dressed up, traditional clothes , erm sometimes er language and I mean accent if they are not born here, and then during interview I usually approach and get to the point where I would ask about their religious or ethnic background because it's kind of important to understand.</p> <p><b>I:</b> and what have you found that people tell you?</p> <p><b>P3:</b> so I've had people be quite open about err talking about their background, I would rather ask open questions about how they identify themselves in terms of ethnicity whether they are religious and if he has what kind of religion they belong to and whether they are practising or orthodox or kind of, like in the Jewish community</p> <p><b>I:</b> mmhmm</p> <p><b>P3:</b> erm yeah...</p> <p><b>I:</b> and how have you found that religion has interacted with the person's mental health when you have worked with Islamic beliefs?</p> <p><b>P3:</b> ehmmmm... interesting question, well it really depends I think we kind of have to think separately about men and women with Islamic beliefs because the level of freedom is different , in my perception, erm and erm men are more kind of erm they have more power or more choices and they are less restricted in the way they live , erm so erm I guess for women there are lots of restricted subjects or themes they might want to speak to a professional but it wouldn't feel</p>	<p>Passive enquiry</p> <p>Assumptions based on ethnicity</p> <p>Islam as Non-Britishness</p> <p>Traditionality</p> <p>Getting to the point of asking</p> <p>Importance or culture/religion</p> <p>Asking (active)</p> <p>Perceived level of religious adherence</p> <p>Not much to say about what SU say about religion</p> <p>Unequal gender relations</p> <p>Muslim women as restricted</p> <p>Muslim men as dominant</p>

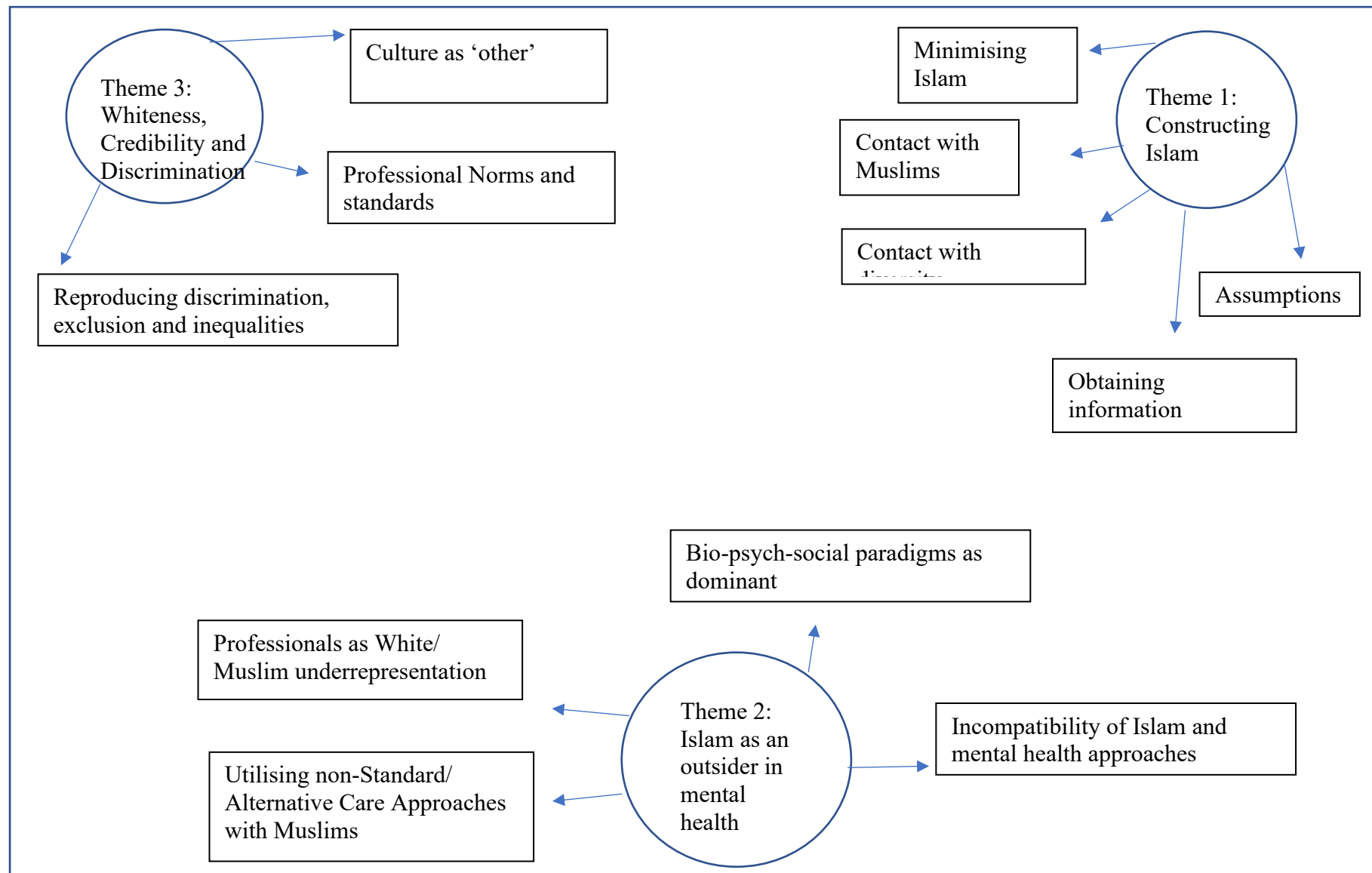
<p>comfortable and it might also affect the openness whether they see a man or a woman or if they are of a different religious background, erm, but that their partner's know whether they have come to see a psychiatrist or psychotherapist in erm general I think that what is going on nowadays with stigma about the terror attacks and well different hot zones, war zones, we have I think it might be more difficult for people of this background to come to a specialist just because they don't want to be exposed on this biased approach or attitude, but also if they have some level of violence as an issue they might be afraid to talk about that, let alone if they have any violent thoughts or paranoid ideas, yea</p> <p><b>I:</b> did these things influence the way you worked with these patients?</p> <p><b>P3:</b> I would definitely feel more comfortable when I am seeing kind of not very religious people , even if they identify themselves as Muslim or having Islamic beliefs but they are kind of westernised, err I don't feel that I have to be that careful in the way I say things or I'm behaving, I mean I don't do anything which is inappropriate but err if someone is very religious I'm not sure what is appropriate and what is not. Erm so I think I would feel more restricted and tense if I know I have to a very religious family for example or a member of the family in the clinic.</p> <p><b>I:</b> hmmm do you feel like that affected the decisions you made or the service you offered people?</p> <p><b>P3:</b> I would be less surprised perhaps if I offer psychotherapy or family therapy to a very religious family, I would be less surprised if they refused this offer and perhaps I wouldn't be very insistent and kind of come back to this discussion later on, thinking that its rather useless and they are not going to accept it, so I think, most likely I would follow the agenda of their expectations if they want medications I would think okay , lets say if I see someone for an adhd assessment, and yea I think I had this ermm experience with adhd when basically you can offer both medication and parent work in a group and if it's a religious family they don't really want to go to groups and mix with other people from different communities erm and I kind of accepted this position more willingly than non-religious families</p>	<p>Impact of culture on engagement with professionals</p> <p>Reference to terrorism/ terror attacks</p> <p>Fear of prejudice from professionals</p> <p>Securitisation of Muslims</p> <p>Violence &amp; Islam conflated</p> <p>More religious=Traditionality</p> <p>Less religious=westernised</p> <p>Worries working with 'religious' Muslims</p> <p>Fear about being inappropriate, questioning self</p> <p>Professionals feeling discomfort/tension</p> <p>Less offers of psychological therapies</p> <p>Assumptions Muslims don't want psychology/ incompatibility</p> <p>More passive in treatment decisions</p> <p>Muslims (reporting?) not wanting to mix? assumption?</p> <p>Discussion of compatibility and cultural difference- passivity how to manage</p> <p>Receiving 'less' services</p>
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<p><b>I:</b> how do these thing get talked about in teams, is this a wider thing you see as well?</p> <p><b>P3:</b> erm it varies from different services I used to work in, so here at (place of work) I'm quite surprised at how much attention we pay to people with a minority background and any kind of aspects that might affect, not only religious but kind of financial and sexuality etc. My previous job in (London borough) we had very mixed community of both well Muslim, Hindu and Jewish patients but it didn't really feel like we paid attention to that, its like it didn't matter, though in the waiting room you would have very traditionally dressed Muslim family and very traditional orthodox Jewish family and it must have difference but it felt like we didn't really have time to discuss this and to pay attention to this.</p> <p><b>I:</b> and how have you related to Muslim service users or their beliefs and practices when you've encountered them in your clinical work</p> <p><b>P3:</b> erm having a (country of origin) background helps for like since presence of (name of government) erm government in the middle east there is some connection with Iranian people, people from Pakistan I guess, when they hear my surname it helps to build rapport kind of from the very beginning and erm there is some type of cultural aspects they know about (country of origin) and it opens the way for my own curiosity to ask how things are working or functioning for you in your religion and your cultural background and they usually accept this curiosity without any suspiciousness and seem open to talking about that but I guess I haven't seen very religious family and I might feel some level of discomfort because I wouldn't understand how I might be able to relate or to connect so when I see a woman wearing the full err headscarf it feels I don't kind of feel comfortable, I wouldn't feel comfortable if I can't see the face and I would feel uncomfortable to comment on that as well so it's really awkward, it would feel a really awkward situation for me. Or if I see a woman who doesn't speak or her husband speaks instead of her, I don't know how to...</p> <p><b>I:</b> What makes that difficult?</p>	<p>'non religious' treated differently</p> <p>Surprise at considering issues of difference</p> <p>Religion 'didn't matter'</p> <p>Comparable to other religions</p> <p>Traditionality/religiosity</p> <p>Reference to historical relations between different countries</p> <p>Being different/non-British as a way of relating</p> <p>Openness related to having not seen very religious family</p> <p>Discomfort towards very religious Muslims</p> <p>Hard to connect/relate to very religious</p> <p>Discomfort with niqab</p> <p>Muslim women as restricted</p> <p>Male/female unequal dynamics</p> <p>Comparing culture/practices to own culture and values</p>
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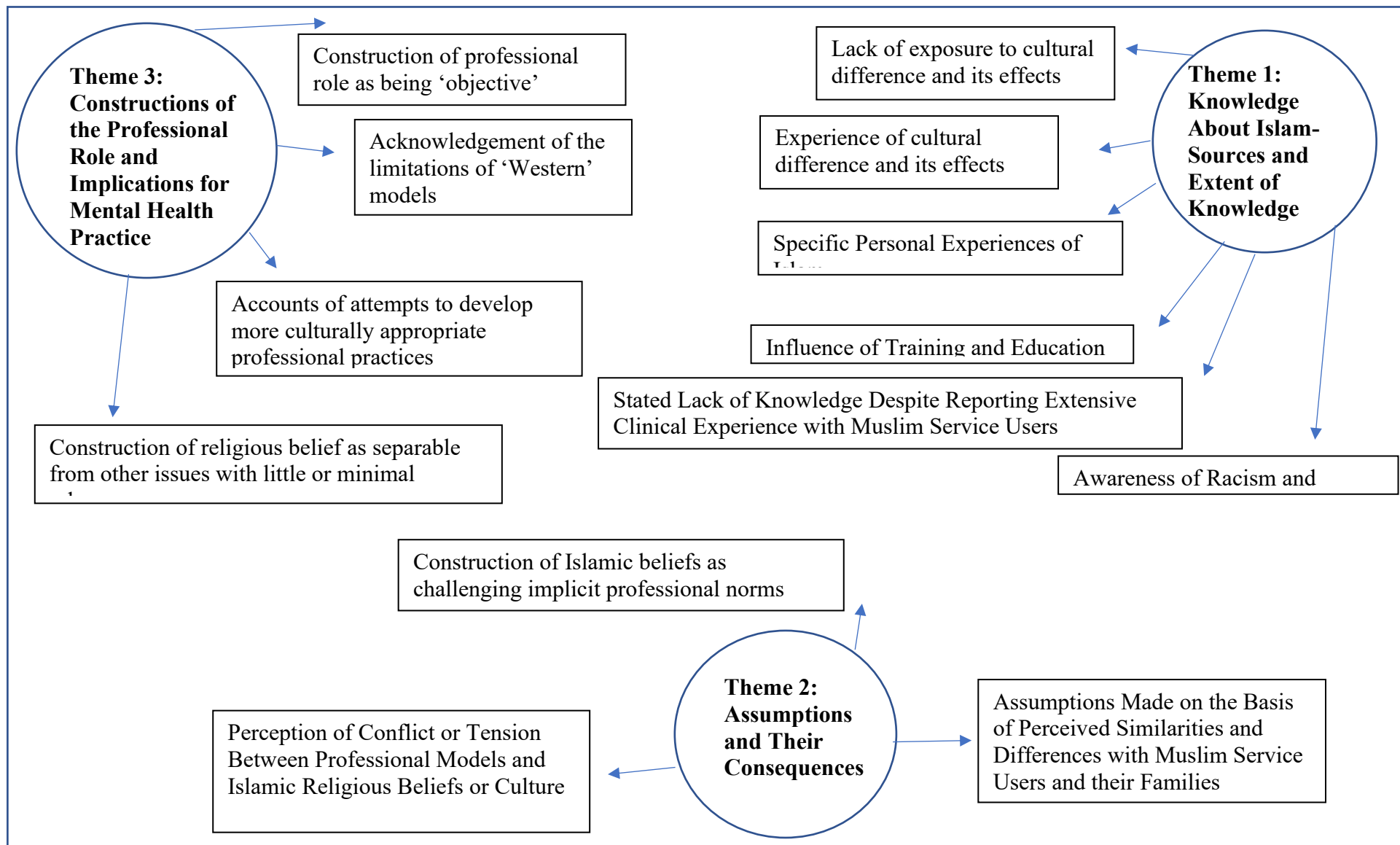
<p><b>P3:</b> Well because it's kind of very unusual to what I've been exposed to in my culture and here erm and I have kind of my own values about equality and about human right and erm I tend to treat women as equal human beings with the same rights as a man so erm that's kind of disagreement with this structure of the family and erm this approach would make it more difficult for me...</p> <p><b>I:</b> and how do you feel that Islamic beliefs or cultures have contributed to Muslim service users' understanding of their distress or 'mental health'</p> <p><b>P3:</b> erm I guess it's kind of a difficult not only for Muslim people but for any erm conventions of religious peoples when we are dealing with serious mental health problems, such as psychosis or bipolar they have their own explanations linked to their religious beliefs and its sort of impossible to change it because you kind of you feel that you have to challenge not just a man with his own ideas and beliefs but the whole community, the whole confession, and without having clear knowledge about what is appropriate for this particular religion and what is not, it's almost impossible to change it, so for like with (specific religious group) orthodox it's normal for Christians its normal to speak to god when you pray but it's abnormal to hear the answer, that is a very kind of simplistic explanation, but when we talk about Islam I would question whether not eating today is normal, I mean whether it's in expected religious behaviour, or whether the patient is suicidal and is refusing food because they want to dies, perhaps I lost the question.</p> <p><b>I:</b> what do you think has helped you to work with these unknowns and differences?</p> <p><b>P3:</b> erm I guess kind of to erm stay in a non-judgemental and erm curious position without giving much information about myself and kind of being open minded about what I hear and avoiding jumping to conclusions and if I have any doubts about what is appropriate and what is not just to speak to colleagues or other people who are more familiar with this religion and also I was... well I was born in south part which is multicultural and it's quite an unusual region where you have different nationalities and different religions, including Islam, (place), this part so I kind of, I was from my childhood exposed to erm that cultures so I know how for example what</p>	<p>Ideas of human rights, equality, feminism?</p> <p>Valued judgement/ disagreement of difference</p> <p>'Religious beliefs' about mental health</p> <p>Something rigid</p> <p>Idea hat these beliefs need changing</p> <p>Uncertainty about what is normal/ appropriate or not in a culture or religion</p> <p>Making comparisons to Christianity as professional's own norm</p> <p>Questioning norm of Islam, consideration of risk/ unfamiliarity</p> <p>Ideas about remaining neutral/ Not giving self away</p> <p>Being non-judgemental and curious</p> <p>Speak to colleagues with more knowledge about Islam</p> <p>Referencing own experiences of living around multiculturalism</p>
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<p>traditions they have around marriage which is very unusual to the one we have for orthodox people and it doesn't look too kind of normal for me and also what was helpful, my first job here, my consultant was orthodox Jewish and the way she treated Muslim patients, the way she looked after them and interviewed them was very helpful to see how she managed to keep her own beliefs behind when she went to work, that was very helpful</p>	<p>Using own religion/Christianity as a norm for judgements of abnormality</p> <p>Unusualness of Islam</p> <p>Professional conduct, managing own views</p> <p>Working cross religions and cultures.</p>
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## Appendix. M. Thematic Map of Candidate Themes



## Appendix N. Final Thematic Map & Excerpt of Process of Refining Themes



### Excerpt of Process of Refining Themes

Here is an excerpt describing how the initial candidate themes were considered and restructured into the final theme structure.

#### Theme 1. Evolving '*Theme 1: Constructing Islam*' into '***Theme 1: Knowledge About Islam- Sources and Extent of Knowledge***'

This theme name was changed to reflect what participants had said about their knowledge about Islam, rather than focussing of ideas of 'construction', which was considered to be reflective of a more theoretically deduced concept. Adapting this theme to discuss how participants came to form their knowledge about Islam was more reflective of the inductive approach to analysis taken and helped to capture the varying sources of knowledge about Islam participants referred to in their interviews, as well as the varying levels of knowledge that existed amongst them.

This theme was initially made up of 5 sub themes, however some of these were expanded to convey the diversity within them and others were moved into other main themes. Knowledge About Islam- Sources and Extent of Knowledge became 6 subthemes following the process outlined below:

Sub-theme '*Contact with diversity*' was split into two sub-themes '*Experience of cultural difference and its effects*' and '*Lack of exposure to cultural difference and its effects*' to reflect the different effects that exposure or lack of exposure to diversity was reported by participants to have on their knowledge about Islam or how to be around cultural or religious difference.

Sub-theme '*Contact with Muslims*' was also renamed '*Specific Personal Experiences of Islam*' to broaden this category to wider experiences of encountering or considering Islam, beyond contact with Muslims. This was also changed to reflect the personal nature of these experiences which participants had drawn upon in discussing specifically how personal contact with the religion had given them insight which impersonal contact may not have. Elements of '*Contact with Muslims*' were also relevant to other main themes, such as **Theme 2: Assumptions and Their Consequences**, therefore unpacking this sub theme further was considered additionally necessary as it was too broad.

Sub-theme '*Assumptions*' about Islam was considered too large to be a sub-theme and was linked to consequences in professionals' judgements and practice and therefore this merged with elements of '*Theme 2: Islam as an outsider in mental health*' to form '***Theme 2: Assumptions and Their Consequences***' which focussed more broadly on the different assumptions about Islam that existed, as both different and similar and how these affected clinical judgments and practice.

Excerpts relating to the sub-theme '*Minimising Islam*' was also considered as better placed in '***Theme 3: Constructions of the Professional Role and Implications for Mental Health Practice***', in sub theme '*Construction of religious belief as separable from other issues with little or minimal relevance*' due to its wider relation to ideas of mental health models and their interaction with religion, however the specific context of Islam was still considered with regards to how this may exacerbate the minimising of Islamic beliefs, practices and needs. Sub-theme '*Obtaining information passive/active*' was also widened and specified, with elements fitting into sub themes of '*Stated Lack of Knowledge Despite Reporting Extensive Clinical Experience with Muslim Service Users*' and '*Influence of Training and Education*' in Theme 1. This was done to capture the theme of the lack of knowledge participant reported about Islam, sometimes despite significant contact with the religion. However, the role of



education and training in influencing their consideration of the religion was also present and these were both considered as distinct sub-themes. Some elements of '*Obtaining information passive/active*' also related to Theme 3, Sub theme 2 '*Construction of religious belief as separable from other issues with little or minimal relevance*' whereby obtaining information about Islam was linked to ideas of whether religious beliefs were relevant to mental health.

## Appendix O. Themes, Subthemes, Coding & Extracts Framework

### Example of Coding Framework Table from Theme 1:

(Please note that not all codes are represented for each theme)

Theme	Sub Theme	Code	Extract
<b>Theme1: Knowledge About Islam- Sources and Extent of Knowledge</b>	Lack of exposure to cultural difference and its effects	Lack of exposure to Islam/Muslims	<i><b>P8:</b> I don't think I knew that much about some of the different religions apart from Christian</i>
		Differences in diversity in UK	<i><b>P2:</b> when I started nursing in (Region of North of UK)...didn't have many other ethnic minorities or religions apart from white British generally, Christian mainly</i>
		Christianity as a point of reference	<i><b>P5:</b> in Britain... religion isn't that important to them and yet they get anchored in a Christian environment, but they just don't notice it really because it's just so normal to them</i>
		Unrelatability	<i><b>P9:</b> because I'm an atheist myself I suppose you know I can't really connect and relate fully to that idea of things being in God's hands and sort of um living by principles or things that have come from religious texts</i>
	Experience of cultural difference and its effects	Exposure to diverse beliefs and cultures	<i><b>P4:</b> I grew up in quite a multicultural community so it's never crossed my mind that there's only one way to see things...friends from different cultural backgrounds and kind of learn you have to under kind of learn about other people's beliefs</i>
		Being a minority	<i><b>P6:</b> Well as someone with identity...ethnically different from the majority of the population...I feel like I perhaps do understand and appreciate the difficulties and the struggle a bit more, things that can be more covert as well as the overt things</i>

		Experiencing misrepresentation and marginalisation	<i><b>P11:</b> I was brought up within a religion....seeing the diversity within Christianity and all the you know the reality of what that looks...you see behind the kind of projection behind the the what people perceive it to be.</i>
	Specific Personal Experiences of Islam	Personal Relationships with Muslims	<i><b>P6:</b> I dated a girl who was from, who was Muslim and that's was what really gave me the insight...you get to experience something on more of a personal level</i>
		Contact with Islamic cultures and Muslims	<i><b>P5:</b> spending time abroad...in Muslim countries maybe and having experienced how friendly people tend to be and how there's a whole different side to the sort of negative public perception</i>
		Demystifying Islam	<i><b>P11:</b> I did learn about Islam at school...so I think I also had been provided with some information that kind of perhaps also demystifies something perhaps</i>
	Influence of Training and Education	Lack of teaching about Islam	<i><b>P3:</b> I don't think that it's something that we really pay attention to during our psychiatric training</i>
		Generalised teaching on diversity	<i><b>P6:</b> I think we've had you know like in inductions we've had lectures which talk about equality and things are mentioned but it's always at a very superficial level</i>
		Dissatisfaction with diversity teaching	<i><b>P2:</b> I mean there's the diversity training... Equality diversity which was a loada rubbish really it was just a task to fill in answers and the questions were stupid</i>

		Lack of specificity when working with Islam	<i><b>I:</b> How would you say the presence of these Islamic beliefs or identities affected the way you worked with people; did it affect it?</i> <i><b>P6:</b> largely speaking I wouldn't say so...in terms of how I would treat them</i>
		Colour-blind/religious blind approaches	<i><b>P7:</b> so sometimes people will say things like I don't see colour or I don't see religion and I'm not necessarily convinced that that is helpful I think people need to be seen and heard</i>
	Stated Lack of Knowledge Despite Reporting Extensive Clinical Experience with Muslim Service Users	Lack of Knowledge about Islam	<i><b>P10:</b> I don't really know much about the religion and I mean to this day I'm still kind of thinking like what is it that that they do in in terms of like practising their faith...</i>
		Extensive experience with Muslims- not knowing	<i><b>P9:</b> I've worked in services where there are lots of Muslim clients before...I suppose I had some understanding about kind of culture and tradition and festivals and things from that but they were very little children so it wasn't something that was necessarily you know we didn't have kind of high level conversations about it so yeah so I was very aware that I didn't know loads and I suppose a bit unsure</i>
		Reliance of Muslim service users	<i><b>P4:</b> I mean I often kind of make it quite clear that if I don't understand something then they have to explain that to me and not to assume things...I have to be quite sensitive about how to approach that</i>
	Awareness of Racism and Prejudice	Commonality of Anti-Muslim Discrimination	<i><b>P9:</b> throughout the course both of them gave examples of treatment they had which was racist or discriminatory</i>

		Links to Terrorism	<i><b>P3:</b> the terror attacks...it might be more difficult for people of this background to come to a specialist because they don't want to be exposed on this biased approach or attitude</i>
		Pathology and Discrimination	<i><b>P1:</b> I've also had patients who have quite severe anxiety and um sometimes have kind of anxious thoughts that kind of that might involve kind of racial....prejudices against them...a lot of the time that is kind of based in kind of past experiences that they have had and then they go on to kind of have many more anxious thoughts that maybe don't always amount to anything</i>
		Muslim professionals experience of Islamophobia	<i><b>P7:</b> I remember I had an experience on my first placement my supervisors said to me "oh im surprised you're fasting I didn't really think you were that stupid" and I didn't really know what to say or what to do</i>

## Appendix P. Description of Themes & Relevance to Research Question

### Research Questions

1. What discourses do mental health professionals draw on when encountering Islam, Muslims or racialised ‘Muslims’.
2. Has this interacted with their clinical judgements, decisions and practice?
3. What influence do the epistemological position, training and diversity of professions have on practitioners?

Name of Theme	Defining the theme	Relevance to Research Q
<b>Theme1: Knowledge About Islam- Sources and Extent of Knowledge</b>	This theme described the extent of participants knowledge about Islam and the sources of that knowledge. It illustrates the varying personal, professional and social experiences and influences which interact in forming mental health professions’ understandings of Islam	Q. 1 and 3  This theme provided information about how various personal, professional and social experiences can all influence the way professionals may construct Islam or interact with dominant discourses about the religion.
Lack of exposure to cultural difference and its effects	Some participants made reference to a lack of exposure to cultural and religious diversity during formative years of their personal or professional development.  The centrality of white and Christian experience in the minds of the professionals was also noted.	Q.1 & 3  This theme noted how a lack of exposure to cultural or religious difference led to reliance on professionals’ own contextual norms as a system of reference when considering Islam.  In this lack of exposure, Islam appeared to be constructed as being in contrast with ‘liberal’ Western norms, potentially drawing on salient essentialising Orientalist discourses of Islam in the West.
Experience of cultural difference and its effects	This theme highlights the influence which some participants felt being exposed to multiculturalism or religious diversity had on their way of	Q1 & 3

	<p>considering and interacting with ‘difference’ in a way that was more open and understanding.</p>	<p>Exposure to ‘difference appeared to support ideas of plurality, and respect for difference.</p> <p>Participants drew upon how their own marginalised identities had exposed them to the limitation of dominant social narratives which made them question these constructs</p>
Specific Personal Experiences of Islam	<p>This theme highlighted the role that having or not having personal experience or encounters with Islam contributed to them feeling they had an understanding of the religion.</p> <p>Those with experiences of the religion reported feeling they had a better understanding or insight, with these experiences sometimes offering them a different insight into the religion to the one they had which was rooted in socially constructed knowledge.</p>	<p>Q1. &amp; 3</p> <p>These accounts made reference to mystifying or ‘othering’ narratives about Islam (e.g. ‘us and them’) and a ‘negative public perception’ of the religion as prevalent in Western discourse.</p> <p>These discourses were seen to be questioned by disconfirming personal experiences of Muslims or Islam where participants had encountered these.</p>
Influence of Training and Education	<p>Professionals often talked about the role that their professional training or workplace experiences played in developing their understanding of Islam.</p> <p>They reported a lack of teaching or training informing them about the religion and therefore relying on Muslim service users they encountered in their work to provide them with this information.</p> <p>This raised questions about how much knowledge about Islam professionals should have and</p>	<p>Q1, 2 &amp; 3</p> <p>Both religion and Islam appeared to be de-emphasised or superficially considered in professional discourses about mental health, leading to the lack of consideration of religious or cultural beliefs in mental health practice.</p> <p>This absence appeared to be constructed or interacted with differently by different professionals. Some professionals,</p>

	<p>how no standard exists for this given its lack of consideration in training.</p>	<p>especially mental health nurses, translated this into an individualised or generic approach to religion and culture in their care provision, whilst the Muslim professional felt that that taking a generalised approach to religion and culture was reductive and marginalising.</p>
<p>Stated Lack of Knowledge Despite Reporting Extensive Clinical Experience with Muslim Service Users</p>	<p>This theme considered how some professionals cited a lack of knowledge about Islam despite having worked with many Muslim service users, this appeared this something that had not been questioned or considered.</p> <p>However, some professionals spoke about being open about their lack of knowledge and this mobilising them to invite service users to give them information or otherwise seek this elsewhere.</p>	<p>Q1 &amp; 2</p> <p>The level of consideration about how much professionals understood about Islam despite encountering it frequently in their work may reflect discourses about how prevalence religion or culture is in mental health care or ideas about Islam as different, unknown or unfamiliar and whether it was worth knowing about. It may also reflect discourses about who the expert and who's knowledge is prioritised in the encounter.</p> <p>Professionals who were more open about not knowing and aware of their position in relation to Islam appeared to consider that their lack of knowledge may lead to gaps in their clinical encounters and invited for service users to fill this.</p>
<p>Awareness of Racism and Prejudice</p>	<p>Many professionals made reference to the increase discrimination against Muslims within the UK context at present and described reports from service users of discrimination experiences.</p> <p>However, this appeared to focus mainly on their clinical contact with this and little was said about how this was responded to or discussed with service users or wider considerations about Islamophobia and how</p>	<p>Q1, 2 and 3</p> <p>Professionals appeared to talk in general or implicit terms about broader negative social discourse about Muslims, however there was little specificity or sophistication about what this entailed.</p> <p>This was talked about as something that happened 'out there' rather than in services'.</p>



	<p>anti-Muslim discrimination may be understood.</p> <p>Some professionals incorporated the impact of discrimination on exacerbating psychopathology.</p>	<p>There was limited information about how participants managed these experiences, however some professionals noted using ‘mental health’ paradigms, such as consideration of discrimination as exacerbating psychopathology.</p> <p>The Muslim professionals’ own experiences of Islamophobia appeared to sensitise them to the need for this to be explicitly discussed, however there appeared to be uncertainty in raising this conversation in other professionals.</p>
<b>Theme 2: Assumptions and Their Consequences</b>	<p>This theme describes the assumptions participants made about Muslim service users and the effects that these assumptions had on their professional practice.</p> <p>Assumptions about Islam are highlighted as being implicitly used as a basis from which clinical judgements were made. This was potentially problematic when Islam was constructed as an obstacle to mental health understanding and recovery or as conflicting with professional models of mental health.</p>	<p>Q1 &amp; 2</p> <p>Common assumptions about Islam included references to ‘traditionality, lack of progressivity/backwardness and of Muslim women as oppressed and limited, matching onto Orientalist discourses about Islam.</p> <p>Some of these assumptions were used in forming clinical judgement about Muslim’s service users’ compatibility with interventions and at times led to them not receiving recommended treatments.</p> <p>This was sometime related to inflexibility professional approaches</p>
Assumptions Made on the Basis of Perceived Similarities and Differences with Muslim Service Users and their Families	Assumptions of traditionality as meaning higher levels or religiosity, less western values was noted to be conflated with Islam. Ideas about Islam as restrictive, less progressive or backwards were also apparent	<p>Q1 &amp; 2</p> <p>Orientalist ideas were apparent in many of the assumptions participants expressed about Islam. There was a colonial sense of inferiority associated with a perceived ‘traditional, closed, rigid Islam’.</p>

		<p>These assumptions were noted as leading to feelings of unfamiliarity, unrelatability with service users and disapproval of certain values associated with Islam.</p> <p>It was also linked to higher levels of alertness, suspicion or concerns about risk for both racialised risk practices and religious practices in general (e.g. fasting). These may be linked to the securitising of Islam and the social discourses conflating violence to Islam, including narratives about forced marriages or honour-based violence.</p> <p>This have implications for the way that people may approach perceived traditional Muslims with more suspicion and securitisation.</p>
Construction of Islamic beliefs as challenging implicit professional norms	This subtheme considered professionals' accounts about Islamic beliefs or practices as being in contrast with elements of their professional approaches, including the role of families and communities, religious conceptualisations of distress and the way that distress may present.	<p>Q1 &amp; 2</p> <p>Discourses about mental health and how professional interventions should be delivered were prominent here as existing in contrast to a more collective or spiritual understanding of distress held by Muslim service users.</p> <p>Judgements and ideas about these different constructs as unhelpful made professionals consider whether or not they should intervene, with a sense that these ideas may need to be changed or modified as common.</p> <p>Such conflicts may be seen as contributing to construction of service users as inappropriate for services (e.g. lack of psychological mindedness) or reluctant to understand a situation in appropriate 'mental health terms' and approach services. Locating</p>

		the problem in service users and unquestioning professional models.
Perception of Conflict or Tension Between Professional Models and Religious Beliefs or Culture	Participants also pointed to perceived incompatibilities or tensions between professional models of working and perceived Islamic religious and cultural factors. This included ideas of Islamic religious beliefs as being restrictive and therefore disabling mental health understanding and recovery.	<p>Q1 &amp; 2</p> <p>Participant spoke about religious or cultural beliefs as limiting the effectiveness of their intervention, again with some queries about whether these should be changed or adapted. Implicit in this is the prioritisation of Western models of mental health.</p> <p>There was a sense that these beliefs would be tolerated so far as they did not pose risk to anybody. Such ideas give priority and power to professionals, reducing the credibility of religious beliefs and securitising them, contributing to the maintenance of western hegemonic dominance.</p> <p>Indeed, this may be depicted in the racialised reframing of different expression of distress into discourses such as ‘somatising’ or ‘culturally specific’, which may subject them to queries about credibility or pathology. This may contribute to misdiagnosis or dismissive and unequal care</p>
<b>Theme 3: Constructions of the Professional Role and Implications for Mental Health Practice</b>	<p>This theme included participants’ constructions of professional roles and practices.</p> <p>The epistemological positioning of professional’s approaches appeared to affect their application of mental health models; with universalism leading to adherence to standard practice and considerations of cultural</p>	<p>Q2 &amp; 3</p> <p>Ideas of the professional as neutral, objective and cultureless and western constructs ‘mental health’ as similarly objective and universal appeared to be rooted in professional discourses that spread across all three professionals interviewed. This appeared reflective of an absent western secular standard.</p>

	relativity leading to critical approaches or adapted practice.	This led to the ‘othering’ of culture in both professional identity and service users care provision
Construction of professional role as being ‘objective’	Professional discourses for the need to remain neutral and objective appeared to be present in professional thus suggesting that professionals did not bring in their own experiences, ideas or cultures into their practice and the perceived dangers of introducing cultural or religious values into care were noted by one participant.	<p>Q2 &amp; 3</p> <p>The implicit Eurocentric and secular norms, which prioritise western understandings and values, in ‘common sense’ ideas about how professionals should practice, appear to be unexamined, suggestive of the ide of an “absent standard” in professional paradigms.</p> <p>This impacted on the range of cultural ideas or values which professional brought to their roles and marked the potential disciplinary consequences of doing so.</p>
Construction of religious belief as separable from other issues with little or minimal relevance	This theme notes participants’ accounts of separating religious ideas from their understanding of ‘mental health’. Religion was often seen as peripheral and therefore not thoroughly inquired about, emphasised or integrated into frameworks of understanding service user’s mental health. This was noted to be in direct contrast with Muslim and Islamic conceptualisations of mental health	<p>Q1, 2 &amp; 3</p> <p>Constructions of ‘mental health’ appeared to see culture or religion and ‘separate’, epistemologically privileging secular and western discourses about mental health as universal and of the most relevance. This appeared to constrain participant’s interaction with these factors.</p> <p>The real constraints on professionals’ time and what they are told to prioritise within this within western frameworks of interventions appeared to further limit their inclusion of religious or cultural factors into care provision, except for in relation to practical adaption to support the practice of religion.</p>

		<p>Feelings of discomfort in asking about religion may be further linked to constructs that exist about Islam specifically. However, the disproportionate impact this had on Muslim service users due to their religio-cultural identities was noted by the Muslim professional interviewed, who questioned their role fulfilment when providing religious and cultural care.</p>
<p>Acknowledgement of the limitations of 'Western' models</p>	<p>The theme captures the critical ideas expressed by some professionals interviewed regarding the limitations of the models and approaches used in mental health practice when applied to non-western cultures. However, there were limitations in how this could be understood as producing inequalities and talking about the presence of discrimination in services appeared to be challenging</p>	<p>Q1, 2 &amp; 3</p> <p>Some professionals showed critical consideration of the appropriateness in applying Western literature and theories about mental health to culture and context where understanding about these experiences diverged from western experience, especially when they had encountered critical approaches in their training. A lack of awareness or consideration of the cultural and religious needs of Muslims was noted as leading to misunderstandings about Muslim service users' interest or willingness to engage with services, potentially leading to them not receiving further support. This may be understood as relating to the role of projection within racial power dynamic and discourses about Muslims as closed.</p> <p>Some references were made to the role of professionals' judgements in the disparities in service access by Muslims, however this appeared very tentative and there seemed to be some hesitation in labelling these disparities as relating to structural inequalities or discrimination. This may be noted as relating to professionals' privileged identities as the</p>

		‘burden’ of discussing these matters appeared to fall to the Muslim professional interviewed.
Accounts of attempts to develop more culturally appropriate professional practices	This subtheme highlights the attempts made by a number of participants to adapt their practice to include more culturally appropriate modes of care. This often began with recognition of practitioners’ own limitations in understanding a cultural or religious difference and then involved the utilisation of alternative models or local support resources in order to enhance their interventions	<p>Q1, 2 &amp; 3</p> <p>Awareness of own limitations in understanding a cultural or religious difference and the availability of epistemically relativist approaches or cultural or religious experts appeared to support professionals in providing flexible and inclusive interventions.</p> <p>Willingness to enter Muslim communities and frames of reference appeared to also facilitate this and this appeared to be facilitated by both availability of resources and experiences which made this seem more acceptable and comfortable to the professional.</p> <p>However, the sense of having a right to a space in mental health which was considerate of cultural and religious identity in professionals spaces appeared novel and exceptional to the Muslim participant and reports of resistance and uncertainty from wider teams and team members about the inclusion of Islam or religious and cultural difference were noted. This may relate to discourses about the assimilability and compatibility of Islam in the West or religion in mental health and highlights the potential risk for professionals who advocate for these in terms of repercussions they may face regarding their professional integrity and belonging.</p>

## Appendix Q. Reflective Diary Extract

### Reflexive Diary Extract - Reflections after Interview 4

This was the third interview and felt slightly different to the others. The participant appeared more nervous than I had anticipated from the other three interviews. The others seemed more confident about speaking about this topic and their work without much prompting, however at times I felt that I was having to be more pushy for answers with this interviewee, using more prompts and asking them if they could say a bit more.

It felt quite procedural at first, almost as though I was testing this person and they were trying to give me the right answer. It was the first interview where I felt the potential sensitivity of this research topic. Which was interesting. It made me realise that in the previous interviews the conversation had been quite light, despite there being many things that I had felt were quite stereotypical and potentially problematic about the way Islam and Muslims had been spoken about, especially Muslim women. However, despite those ideas being things that could easily be assumptions made about me, I felt as though I needed to maintain a neutrality and facilitate the professional's talk, for the sake of the study and for my role as a researcher. However, I guess it has only just struck me the complicity I may have been drawn into with such ideas, or maybe more the sense that this was just 'common sense' understanding of Muslims or Islam that I would just naturally adhere to. Or that ideas like human rights and equality somehow leverage a certain amount of power in justifying ideas, even when they go on to suppress others, like with White Feminism. It made me curious about how I may be positioned by participants, based on my name, my interest in the topic, maybe the way I looked.

I had been asked already on a couple of those occasions what my interest in the topic was, always after recording had finished and after we had ended the interviews. Perhaps placing me in this topic was in people's minds. I considered their interest in the research topic and their expressions of genuine commitment to contributing to something that might improve Muslim service users' experience and the strange balance between this positive regard and the unintentional harm some of their ideas might have.

Anyway, this interview felt like a different position, like somehow I was the aggressor, asking about Islam. I felt I had to be careful how I raised the issue, how much I pressed in or emphasised the importance of it. Perhaps a projection of the difficulty of talking about this topic from a privileged position (non-Muslim/White). However in many ways it made me think about all the doubts I've had about whether this project was relevant or important, whether I was making a deal about nothing and then I considered the absence of such research, and the absence of Muslim service users or voices in mental health. Interestingly as the interview developed the participant spoke about their fears of getting things wrong and there appeared to be more ease and warmth after that. I realised that this was defiantly another side to being related to a topic.

I'm left thinking about the human behind the feelings elicited by these varying positions one can enter into when encountering social dynamics of power and how expressions of common humanity appeared to at least begin to make amends and heal some of the misunderstandings or tensions that existed around these positions. However, warmth appeared to be lacking in

the participants accounts of talking about Muslim service users, so far; perhaps that is something that needs to be thought about. Maybe that's how we profess talk about service users, but maybe especially for some. It makes me think about the warmth I've felt to service users, where this has varied and why.



